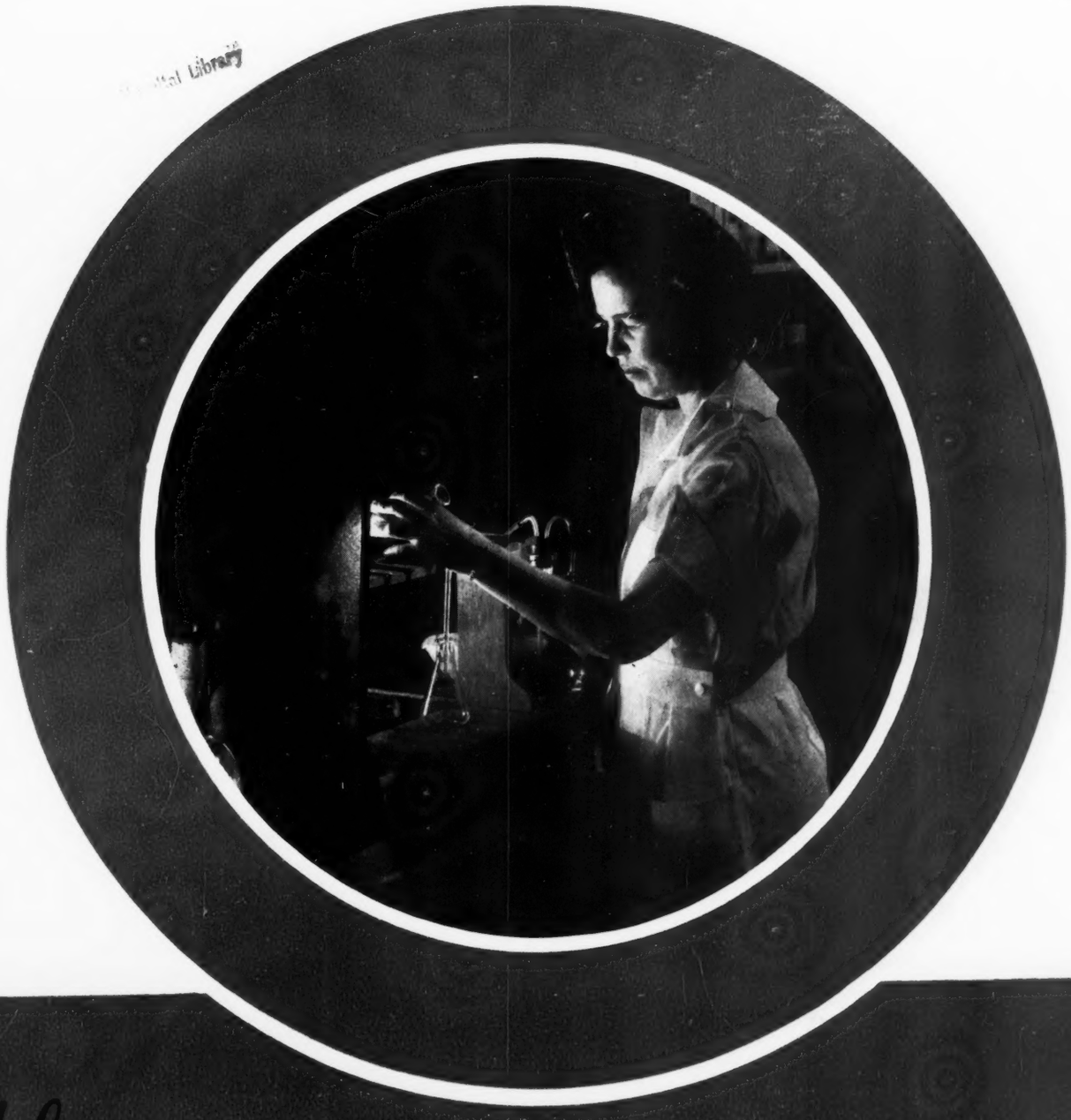

the MODERN HOSPITAL

VOLUME 54 APRIL 1940 NUMBER 4

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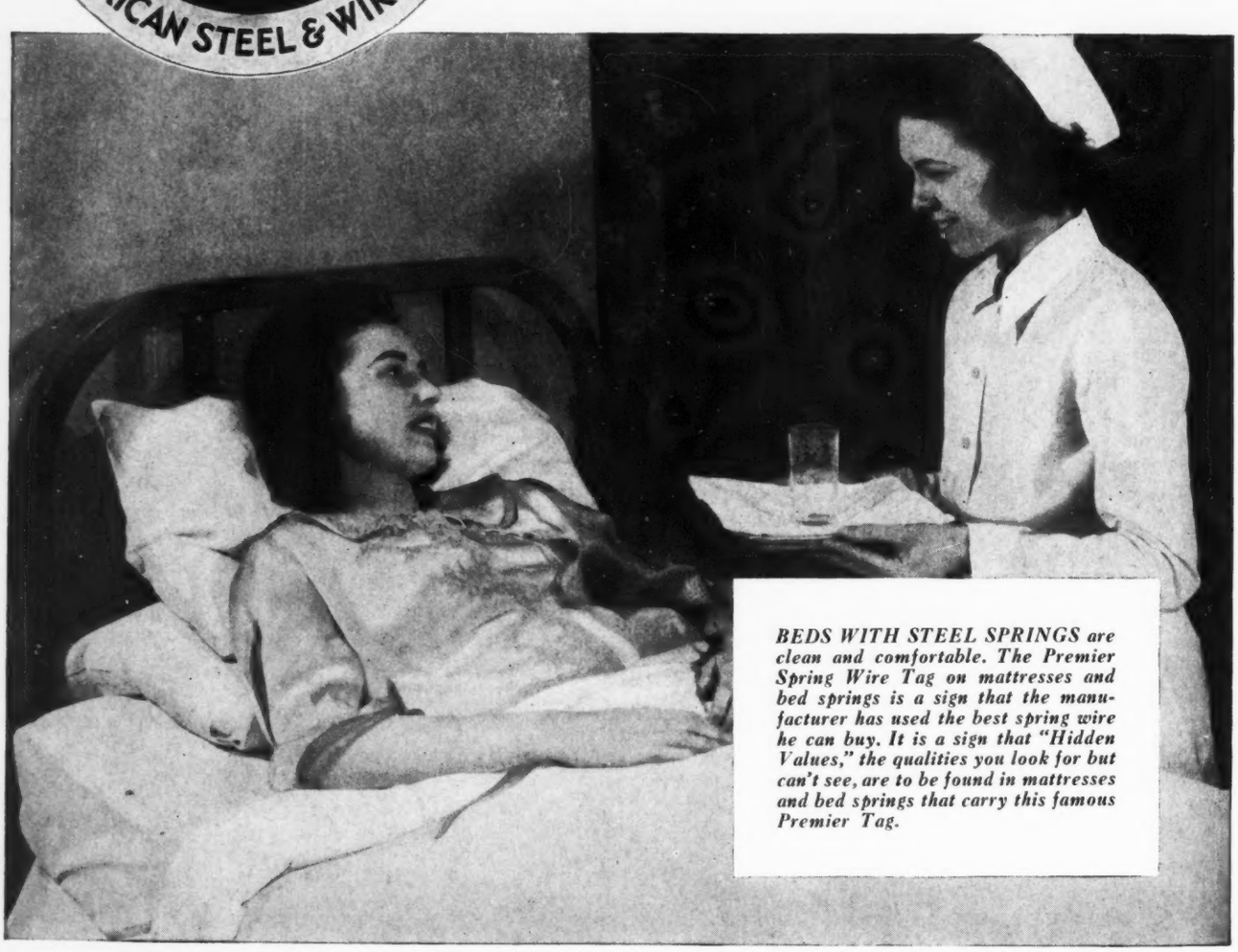

***BEDS WITH STEEL SPRINGS** are clean and comfortable. The Premier Spring Wire Tag on mattresses and bed springs is a sign that the manufacturer has used the best spring wire he can buy. It is a sign that "Hidden Values," the qualities you look for but can't see, are to be found in mattresses and bed springs that carry this famous Premier Tag.*

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UNITED STATES STEEL

CONTENTS

For April 1940

Just in Passing—

HOSPITALS have responded so generously to our request for salary data that by the end of the first week we had received more than 1000 replies. They are still coming in. The first article, dealing with salaries for administrators, will appear in our May issue. Then in June will come data on nurses' salaries, to be followed in succeeding months by data on the other department heads.

MODERNIZATION being the watchword of the period, The MODERN HOSPITAL has arranged to continue its emphasis on this subject. Next month Dr. Claude Munger and John M. Stacey will describe the extensive modernization program at St. Luke's Hospital, New York City. The plan adopted there can be modified to suit the needs of large or small hospitals.

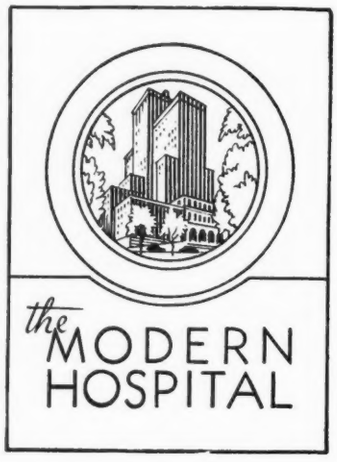
THREE articles next month will give helpful information on planning for the summer comfort of the sick. Doctor Doane will outline the general steps to be taken and Dr. John Gorrell will describe a new advance in air conditioning—panel cooling. The dietetics department will feature a symposium on summer desserts.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent		
Supt. of Nurses		
Surg. Supervisor		
Dietitian		
Housekeeper		
Pharmacist		
Engineer		
Laundry Manager		
Radiologist		
Pathologist		
Chief of Staff		

Return to

The Modern Hospital



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EASY TO USE...RESULTS ASSURED

● Antiseptics and germicides in their various forms are the most widely prescribed of all prescription products. Prominent in this field are 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly) and its preparations. Among the latest additions to the line is 'Sulfo-Merthiolate' (Sodium *p*-Ethyl Mercuri Thiophenylsulfonate, Lilly) 1:1,000 Surgical Powder, for topical application. The product is a 1:1,000 concentration of 'Sulfo-Merthiolate' in a base of kaolin, sodium bicarbonate, magnesium stearate, and benzoin. It is recommended in the treatment of infected wounds and ulcers, vaginal infections, and as a protective antiseptic for cuts and abrasions. Supplied in 1 1/2-ounce sprinkler-top containers.

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- 'Merthiolate' Ophthalmic Ointment 1:5,000—in 1/8-ounce tubes
- 'Merthiolate' Solution 1:1,000—in quarter-pints, pints, and gallons
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Services Offered

• The little announcement of Volunteers' Service that every patient receives on admission to the Princeton Hospital, Princeton, N. J., is well worth examining. At the top appears the insigne of the hospital, a cross with the word "service" running horizontally and vertically, which, William J. Donnelly, the superintendent, tells us, was the idea of one of the trustees.

Beneath the cross we read—"The Princeton Hospital volunteers offer the following for your convenience: general information furnished, books and magazines supplied, reading aloud, flowers arranged, telephone calls made, letters written and messages sent. Volunteers will also be glad to perform errands uptown.

"Should you wish to avail yourself of any of the foregoing, a nurse will be glad to call a volunteer during the following hours:

"Mondays through Fridays—10 a.m. to 12 m.; 1 to 4 p.m.

Saturdays—10 a.m. to 1 p.m.

Sundays—1:30 to 4 p.m."

"The volunteers," it is explained, "are a group of Princeton ladies who contribute their services in an effort to make your stay in the hospital more comfortable and pleasant."

"Calling All Calendars"

• What is this: "a drive on the unsightly calendars that have sprung up all over the building with the coming of the New Year"? Your Roving Reporter was reading from a copy of "The Blade," a clever little mimeographed sheet prepared and distributed by the employes of the Battle Creek Sanitarium, Battle Creek, Mich. Incidentally, how is that for a title? It has a good slogan, too, and one that fits it admirably—"the sharpest little newspaper in town."

To get back to our subject, fancy, garish calendars tacked on the wall have always been one of your Roving Reporter's pet aversions, so he continued to read with growing interest. "For a long time billboards have been a menace to the beautiful scenery of the countryside until now they are prohibited in some states. They have been accused, and rightly so, of being disturbing to the mental uplift. And so it is with calendars. For the most part they are unsightly and disturbing to the patients.

"Our visitors come here to get away from time and its many demands, and it is inconsiderate for us to have enormous calendars hanging ever before them screeching out the days and dates that are ever remindful of some business problem.

"So let's have a new slogan for a few weeks—'Calling All Calendars' for disposal in desk drawers or in other out-of-sight places."

It sounds like pretty good hospital logic, don't you think?

"Capping" Exercises

• What superintendent of nurses is looking for ideas for "capping" exercises? This question is prompted by witnessing a dramatic moment at the University of Virginia Hospital, University, Va., when its preclinical students were accepted into the school of nursing.

Each girl held a candle; those of the senior nurses were lighted and those of the students, unlighted. As each preclinical student received her cap she lighted her candle from a lighted candle of one of the seniors. When all of the candles were lighted the freshman students repeated the Florence Nightingale pledge. Then an arch was formed by the freshmen with their lighted candles, under which the seniors marched singing the school song, "The Good Old Song."

The program had other features, too. Dr. C. S. Lentz, superintendent, gave an address and music was supplied by the glee club of the school of nursing. After the exercises, tea was served by the freshmen.

Capping the student nurses at the University of Virginia Hospital.

When Nurses Have Dates

• Should nurses be allowed to entertain men friends in their quarters, when those quarters happen to be the upper floor of a small hospital—especially a small hospital that is located in a small town?

Highland Hospital at Belvidere, Ill., for many years did not allow men on the second floor. Recently, Esther Wenger, the superintendent, has changed this rule. Men may now be invited by the nurses to a large social room at the end of the second floor hall.

In most small towns, Miss Wenger points out, the places available for social entertainment are relatively limited. She would rather endure a certain amount of inconvenience by having men on a nurses' dormitory floor than to have nurses meet their friends in roadhouses.

Cyclopropane Squibb

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THE extreme care used in the production of Cyclopropane Squibb results in a gas of exceptional purity. Exacting control begins with the selection and testing of the raw materials. Elaborate purification methods are employed and careful chemical analyses are made of each lot before it is released for sale. In addition, representative lots are biologically tested on rhesus monkeys.

The high quality of Cyclopropane Squibb has been amply demonstrated by clinical experience and the product has been generally accepted by anesthetists throughout the world as a dependable anesthetic agent.

Cyclopropane Squibb is supplied in 30 (AA)-, 75 (B)-, and 200 (D)-gallon cylinders. The cylinders are made of special steel which makes them light in weight, yet comparable in strength to the old-type, heavy cylinders.

Note: Cyclopropane is a highly potent gas and should be used only by anesthetists familiar with the technique of its administration.

For literature and information on Cyclopropane address the Anesthetic Division, 745 Fifth Avenue, New York

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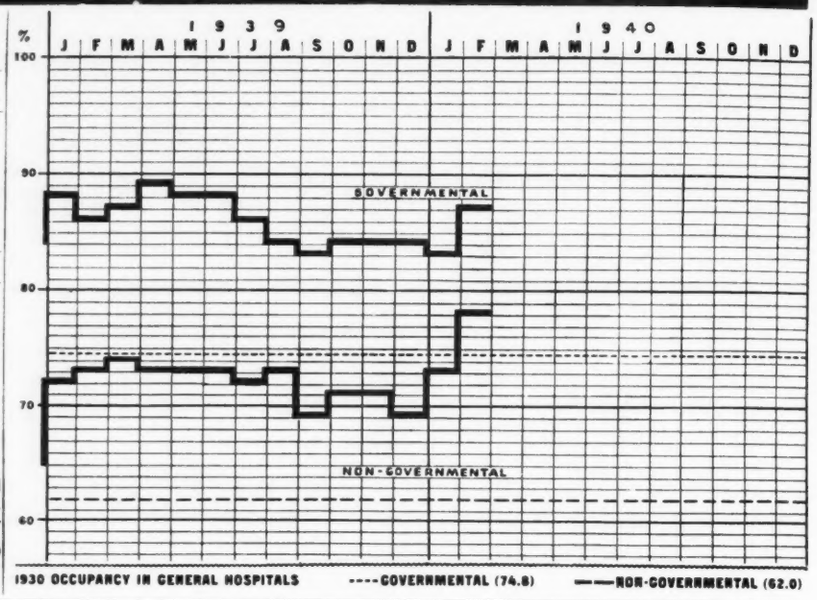
HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1940: Feb.	1940: Jan.	1939: Feb.	1939: Jan.
Governmental:						
New York City	17	10,659	96*	96*	108	106
New Jersey	4	2,236	88*	88*	92	87
N. and S. Carolina	18	2,221	82	77	70	72
New Orleans	2	3,824	77	69	97	98
San Francisco	3	2,255	101	98	90	90
St. Paul	1	850	74*	62	76	76
Chicago	2	3,500	94	92	88	89
Total[4]	47	25,545	87*	83*	89	86
Nongovernmental:						
New York City[3]	68	15,194	71*	71*	81	77
New Jersey	64	9,938	66*	66*	75	73
N. & S. Carolina	107	7,081	74	71	68	64
New Orleans	6	1,126	85*	82	73	75
San Francisco	16	3,178	80	76	77	75
St. Paul	9	1,078	85	78	77	68
Chicago	22	3,983	71	68	70	66
Cleveland	9	1,336	90	80	81	78
Total[4]	301	42,914	78*	74*	75	72

[1]Excluding hospitals for tuberculous and mental patients and Institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1010 of The Eighteenth Hospital Yearbook.



February Occupancy Reaches Peak

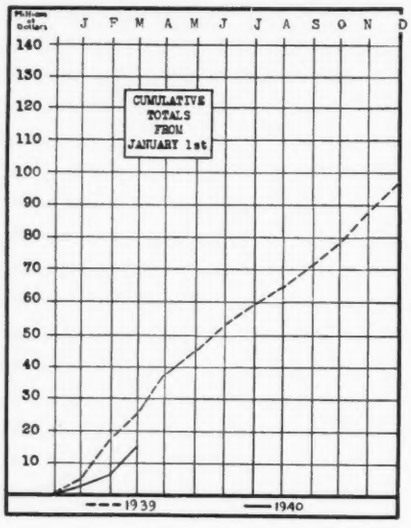
The highest occupancy in the history of the nongovernmental hospitals since the present record was started in January 1933 was recorded last month when the average February occupancy of the institutions reporting to The MODERN HOSPITAL reached 78 per cent!

Previous February reports were as follows: 1939, 75 per cent; 1938, 73 per cent; 1937, 72 per cent; 1936, 68 per cent; 1935, 62 per cent; 1934, 58 per cent, and 1933, 55 per cent. The increase was general throughout the country, every reporting area participating in the advance. (Reports from New York City and New Jersey have not yet been received.) The advances over January ranged from 3 to 10 points, the former in Chicago and the latter in Cleveland.

Last month several areas were late in submitting reports and those that have come in subsequently brought the January occupancy figure up from 73 to 74 per cent. Probably the February report will also be increased when all data are received.

In the governmental general hospitals, occupancy also is up sharply over January. But the 1940 figure for these hospitals has not, on the basis of available reports, reached the level achieved last year. Nor is it even close to the overcrowded conditions reported for 1933, 1934 and 1935. Apparently the reporting governmental general hospitals have completed the construction of sufficient new facilities and have shifted enough patients to the voluntary hospitals more nearly to equalize the load.

HOSPITAL CONSTRUCTION



Hospital construction took a decided spurt during the period from February 12 to March 11, with 34 new projects reported. These are to cost a total of $9,050,000 (one project failed to report costs). This brings the total new construction reported to date to $14,800,000 since January 1. While this is considerably smaller than the $25,300,000 reported for the similar period last year, the federal spending program was in full swing at this time last year.

In the 34 new projects are 6 new hospitals to cost $5,560,000; 25 additions to cost $3,347,000; 1 alteration to cost $13,000 and 2 nurses' homes to cost $130,000.

General wholesale prices sagged slightly during the period from February 17 to March 16, according to the index of the *New York Journal of Commerce,* which dropped from 81.5 to 79.6. Grain, food, textiles, fuel and building materials all dropped in price. Grain prices fell from 76.1 on February 24 to 73.7 on March 2; jumped back to 75.8 the following week and fell off again on March 16 to 74.2. Food prices, which had climbed to 69.1 on February 17, showed a slight but steady decline, dropping to 67.6 on February 24 and continuing down to 64.9 on March 16. Both fuel and building material prices remained almost stationary, fuel declining seven-tenths of a point, and building materials, five-tenths. Drugs and fine chemicals, however, advanced slightly.

SMALL HOSPITAL QUESTIONS

This department is conducted with the cooperation of Gladys R. Brandt, R.N., Cass County Hospital, Logansport, Ind.; A. F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Oliver K. Fike, Grace Hospital, Richmond, Va.; Mrs. Jewell W. Thrasher, R.N., Frasier Ellis Hospital, Dothan, Ala., and others

Fee Schedules

Question: There are two hospitals in our town. Recently the superintendent of the other hospital asked me if we could not get together and adopt a similar fee schedule. Now some of our fees are higher than theirs and some are lower. We have a better radiologist, I think, than they have, but they have a more modern building than we do. Shouldn't we charge more for x-ray and they charge more for room? What do you suggest?—J.R.C., La.

ANSWER: Your x-ray charges should be the same; otherwise you will probably lose a great deal of your x-ray work. The public is seldom able to appreciate the better radiologist. On the other hand, it would be wise for you to spend a little more on equipment, make your rooms attractive and charge the same rate as your competitor. The type of building will have little or no influence if the patient has good service in a comfortable room.

Equipment for Small Laundry

Question: We have a 25 bed hospital and are considering purchasing laundry equipment. Is it necessary for us to have a pressure sterilizer for sterilizing linen inasmuch as plenty of hot water and soap is used in the washing process. We do not as a rule accept contagious disease cases and, when one appears, all linen is put through an antiseptic solution before it is put in with the general laundry. Any suggestions that you can offer as to the best methods of running the laundry will be appreciated.—H.S., Kan.

ANSWER: Pressure sterilizers are not essential. Tests have proved that bacteria are killed in the modern process of washing. The small hospital that has facilities for hanging linens in the open air has the ideal form of sterilization. The water used for washing and rinsing linens (not woolens) should be 160° F. A water softener increases economy and efficiency.

Two women will probably be needed to handle the laundry in a 25 bed hospital. The laundress should report, say, at 5:30 or 6 a.m. and the ironer, at 8 a.m., both working eight hours with an hour or half hour off for lunch.

Isolated linen should be sent to the laundry in special containers for special treatment; stained linen may first be rinsed on the floor and then treated in the laundry.

As for equipment, one large sized double washer may be needed or else two washers, one for washing and one for rinsing. A domestic wringer should be adequate to extract the water. A small sized commercial tumbler is important because it saves much ironing.

Oxygen Service

Question: How can a small hospital provide an oxygen service? What charges should we make for this? Should we use "medical" or "commercial" cylinders of oxygen?—W.C.K., Me.

ANSWER: The smallest hospital should be able to provide oxygen service. Tents are fairly expensive but they have their advantages over other methods. The face mask is one of the best types of apparatus for economy's sake, because it requires less oxygen and less attention than the tent. The catheter method is probably cheaper than any other and still has its uses in the hospital; it is simple and economical to operate. The charge for the service will have to be based on the cost of oxygen and the type of apparatus used. By all means use "commercial" oxygen; it is much less expensive and is chemically as pure as the medical variety.

Contagious Disease Technic

Question: Should our student nurses be allowed to sleep in the nurses' home after they have been nursing a contagious disease case? If not, what can we do with them? When can they return to the nurses' home? If they sleep in the nurses' home, should they take any special precautions before entering it? Also, where should they eat their meals? —F.B.A., N.H.

ANSWER: This question is difficult to answer without a knowledge of your physical setup. Let us, therefore, suppose that yours is a hospital of 50 beds or under. No doubt, strict contagious disease technic is employed by the student nurse in the care of patients. Theoretically, the nurse is noninfectious when she comes out of the patient's room. If she does not have a room of her own, she should have one assigned to her while she is on the contagious case and should be allowed to sleep there. She should not be allowed to mingle in the nurses' home, however. I think that while she is on duty, she should eat her meals with the patient; when she is off duty, she may eat in the regular dining room. All of this presupposes good contagious technic and adequate throat cultures, combined with common-sense methods of partial isolation when off duty.

Exterminating Cockroaches

Question: We have been having a struggle with cockroaches in our kitchen during the past few months and will appreciate any suggestions that will help us to eradicate these pests.—J.B., Kan.

ANSWER: Cockroaches are frequently carried into the kitchen with groceries and other produce. They dwell in damp warm cracks and crevices that are common in kitchens equipped with built-in wooden furniture. The roaches thrive on food debris found in kitchens that are not kept scrupulously clean.

The successful extermination of these pests requires a threefold approach: (1) prevention, (2) obliteration of cracks and crevices and (3) good housekeeping.

Ten years ago, when the Municipal Tuberculosis Sanitarium, Peoria, Ill., was reorganized, the new administration had to deal with a serious cockroach infestation. For the purpose of preventing them from being brought into the kitchen, a root cellar was built outside the building across from the kitchen. All produce is delivered there, unpacked and washed before being taken into the kitchen or stored in the refrigerators. Cracks and crevices were eliminated by the removal of the old built-in cupboards and other wooden furniture. Then a professional exterminator was employed for a systematic eradication. The kitchen was refurnished with all metal equipment and work tables were topped with stainless metal.

All the new equipment is mounted on legs and is set away from the walls, so that every nook and corner around and underneath it can readily be cleaned.

Constant vigilance is necessary, in addition to all the precautions taken. We have a yearly contract with a reliable exterminating firm that inspects the premises every sixty days. It is the duty of all employes to report the presence of roaches immediately to the assistant superintendent, who has charge of the kitchen, so that a thorough search and extermination can be conducted at the beginning of any invasion. With such care, it is a rare occasion when a roach is found.

LOOKING FORWARD

Should the Board Be Educated?

HOW much should the board of trustees know about hospital administration? There are two schools of thought. The one adheres firmly to the belief that too great knowledge tends to encourage intrusion in administrative practice—to make meddlers. In consequence, the trustee is deliberately kept uninformed. The other holds to the theory that in these days of uncertainty the trustee should be better educated, should know something of departmental activities and administrative practices. Therefore, he is initiated.

What neither of these groups has stopped to consider, perhaps, is that with or without sound knowledge there will always be meddlers. The fault lies not with the degree of education but rather with an inherent human trait. The question, therefore, resolves itself to whether meddling borne of complete ignorance holds greater or less potential danger than meddling prompted by definite knowledge.

While adhering to its primary function as a policy-making body, there is no reason why the board, under intelligent leadership, should not only become acquainted with administrative practice but also aid and abet it. Otherwise, why go to the trouble of selecting as members those of high rank in industry or the professions?

Who will say that a qualified engineer should not investigate power house problems or that a public relations counsel or advertising executive should not study the hospital's relations with its community?

Why should not the deadly dullness of the average board meeting be dissipated by some feature that will prove both entertaining and instructive, such as a brief discussion by a department head regarding the work of his or her department! Demonstrations of new apparatus or some new method of treatment by a member of the medical board will also awaken interest. Better understanding and closer cooperation between board members and administration should be the aim. Given a hospital president who exerts proper control of his group and given an administrator who speaks with authority and is not afraid to raise his voice when occasion demands, there need be little to fear from those who evince a perfectly normal tendency to meddle.

Review of Tuberculosis Data

THE special tuberculosis number of the *Journal of the American Medical Association,* published last month, not only presents a great quantity of important facts about the facilities available in American hospitals in 1938 for the care of this disease but also serves to focus attention upon it.

The number of beds available for patients with tuberculosis now totals 98,801 compared with 95,198 in 1934. Present beds are distributed as follows: 70,713 in sanatoriums, 25,944 in departments of other hospitals and 2144 in preventoriums. Of the tuberculosis departments, 244 are in nongovernmental hospitals and these contain 2708 beds, an average of about 10 beds per department. This is an increase of 10 departments since 1934. In view of the increasing recognition of the importance of tuberculosis in general hospitals, this is hardly a satisfactory rate of growth. The average occupancy in these beds was 79,300 for 1938 and the waiting lists total 8797. Thus, while there is a shortage of beds in some areas there is an oversupply in others, inasmuch as tuberculosis hospitals can properly maintain a higher average occupancy than can general hospitals.

General hospitals may, perhaps, wonder how sanatoriums are able to give adequate care with one registered nurse for every 12 patients, plus one unregistered or student nurse or attendant for every 10 patients. Combining registered nurses, unregistered nurses, student nurses and attendants gives a total of 11,339 nursing personnel for an average daily census of 60,511,

or a ratio of about one employe to five patients.

The growth of diagnostic and therapeutic facilities in the sanatoriums and hospital departments is steady and gratifying. These include tuberculosis clinics, x-ray and laboratory departments and facilities for pneumothorax.

A Disappointing Decision

Hospital care insurance for the employes of the American Medical Association has just been arranged through one of the large life insurance companies. This action will come as a distinct disappointment to the hospital field and, no doubt, as a surprise to the rank and file of the medical profession, which has been led to believe that the officials of the association are supporting and encouraging the development of nonprofit hospital plans.

Facts—the Basis for Action

THIS is census year. The hospital field is not having a regular full-fledged census, in view of the fact that the business census of hospitals was conducted so recently by the United States Public Health Service and the bureau of the census. However, the latter bureau is taking a brief census of hospitals in order to compile an up-to-date and comprehensive list of existing hospitals and related institutions that will assist the bureau in its work on vital statistics. Certainly, no one will question the importance of adequate vital statistics in guiding effective health work and hospitals will doubtless be glad to cooperate in this work.

The MODERN HOSPITAL is engaged in a more modest statistical undertaking. As a result of numerous requests, the editors have decided to compile information on salaries of hospital administrators and department heads. The schedules have been sent to all nongovernmental general hospitals in the United States and Canada. Already results have begun to pour in in great volume.

While data on salaries must be used with care and there are many pitfalls for the unwary, it is believed that such a study will perform a useful purpose and provide information that every administrator can study with profit.

Payments for Care of Indigents

VOLUNTARY hospitals must soon develop a reasonable and consistent policy regarding the rates that they should charge for the care of the indigent and other wards of the government. It is heartening to know that some administrators and trustees are giving thoughtful attention to this problem.

Admittedly, hospital charges to governmental agencies must go up. Charges at $2 or $3 per patient day, which may have been satisfactory 15 years ago, are no longer adequate. This is due to the increasing complexity and, hence, the cost of hospital care, to the smaller number of patients who can pay full cost or more and to the decrease in private gifts.

Voluntary hospitals have not demanded in the past and should not now demand that governmental bodies pay them full cost to the last nickel. These hospitals must safeguard their position as charitable agencies, including as it does exemption from taxes and the right to call upon the public for gifts. One way to safeguard this position is by continuing to share with governmental agencies the responsibility for the care of the indigent as far as they are able.

The government must be ready to increase its appropriations to voluntary hospitals sufficiently to replace what they have lost in gift income up to a maximum of the true cost of comparable care in governmental hospitals. If it fails to make this increase, it penalizes the hospital, the hospital employe and, eventually, the public.

Of course, no governmental agency should be asked to pay a voluntary hospital at a higher rate than it would cost the government to provide care of equal scope and quality in its own institutions. But in computing this cost, it is only honest that all items be included whether they are direct or indirect costs and whether they come from the current budget pocket, the bond issue pocket, the P.W.A. or W.P.A. pocket or any other pocket.

Questionable Practice

THE radio and press avidly seize the opportunity to publicize the need for the rare types of blood or that from a patient who has recovered from bacterial endocarditis or leukemia. Many physicians believe that patients suffering from these diseases cannot be cured by transfusion, and when a volunteer comes forward in response to an appeal, it usually results only in creating false hope in the minds of anxious relatives and is seldom of actual benefit.

It has undoubtedly been proved that the transfusion of blood is often helpful in the case of asthenia or in acute or chronic disease, and it is sometimes life-saving when a massive hemorrhage has occurred. Nevertheless, while there are few more dramatic procedures practiced in the hospital than the transference of blood from the well to the sick, it is hardly fair to permit the public to believe that the infusion of 200 cubic centimeters of blood is a cure-all. If and when the blood transfusion pendulum swings back to reason and normalcy, much time, effort and money will be saved both to the hospitial and to its patients.

Your Second Front Door

G. F. STEPHENS JR.

A HOSPITAL in its public relations program marks the information desk for special consideration. But the telephone switchboard is usually dismissed with a passing reference to the necessity for courteous operators. More and more hospital services are being compared with similar activities in other organizations and we must strive to meet the standards set for us by the public.

The telephone switchboard, the hospital's second front door, is no exception. Telephone officials often consider hospital switchboard service decidedly inferior to that of business where many hotels, stores and offices have efficient and courteous switchboard personnel and adequate mechanical facilities for handling customers' calls. Good telephone service must pay; otherwise business concerns would not consider it such an important part of their public relations program.

Telephone procedures have changed in recent years. This is reflected in the better reception now given to a caller both by the switchboard operator and by the department with which he is connected. The drowsy "Hellao" or "Hospital" has been replaced with a friendly and brisk but not brusque "General Hospital." Acknowledgment of the subscriber's order is made with a pleasant "Thank you." Good practice now dictates that the person who answers a departmental telephone will identify the department and give his name, *e.g.* "Admitting Office—Miss Brown."

What is expected of a hospital switchboard in the way of service? It must give prompt courteous service to two groups of subscribers: the public, which expects a standard of service equivalent to the courtesy and solicitude of a first-class hotel, combined with the instantaneous response of the fire department; and the intramural subscribers, ranging from the administrator to the newest probationer, each of whom feels that his call merits immediate attention.

It is all right to talk about good switchboard service but good service cannot be maintained unless the operators are provided with the means to give it. The administrator who takes the time occasionally to spend an hour in observation at the switchboard will have a much clearer idea of the problems there. If the hospital is large enough, a survey by a competent independent telephone engineer will be well worth while.

For adequate performance several factors must be considered. Location is important. If possible, the switchboard should be segregated in its own quarters. Even if it must be in the information desk a removable partition will help to free the operators from outside distractions. If this separation is not practical a canopy of sound absorbing material suspended above the switchboard will give much more privacy and will be relatively inexpensive.

For efficient service operators must have enough time for each call so that the caller is assured of a prompt answer yet does not feel that he is being hurried into stating his request all in one breath. Each second a

Reminders for Switchboard Operators

1. **Many more people are in contact with the hospital than come personally to the front door. They expect the same kind of reception on the telephone that they would receive in person. The hospital depends upon you to convey to each caller its friendly willingness to serve.**
2. **Give every caller the same unhurried courtesy and consideration you would give to a personal friend.**
3. **Know where to locate each member of the personnel and how to route enquiries seeking information. Acquaint yourself with the physical location of each telephone so that you may visualize where doctors and others may be located when needed.**
4. **When you are holding an outside trunk call, offer to take a number. If the caller wishes to hold the line give a report at least every thirty seconds to encourage him to wait. When the connection can be established, thank him for waiting.**
5. **If the party asked for is not in the hospital, suggest where he may be found and supply a number whenever possible.**
6. **Keep a list of those who are on vacation, the dates and names of their substitutes for ready reference.**
7. **Long waits for the operator to transfer a call from one department to another create a poor impression. Watch the recall signals (flashing cord lamps).**
8. **Know the exact procedure in case of an emergency. This includes routine hospital emergencies, fires in the building, outside fires, riots and other disasters.**
9. **If the subscriber gives his name or you already know it, address him by name in giving reports. Everyone likes the sound of his name.**
10. **When taking messages avoid mistakes by repeating numbers and spelling names.**
11. **Take down connections promptly on the disconnect signal.**
12. **Finally, the impressions the hospital makes over the telephone are more important than most of us realize and are a vital part of proper public relations.**

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caller waits for an answer seems like a minute and the longer he waits the more unfavorable the impression that is created. Too often the switchboard operators are burdened with secretarial duties, such as message taking and obtaining information, when these calls can be cared for at once by other departments. Except in small hospitals the switchboard's function should be just "switching."

This system does not relieve the operators of the responsibility for having a comprehensive knowledge of the proper routing of all calls, both ordinary and unusual. The unusual request should reach its destination as rapidly as the routine one. For example, specific instructions should be given for the handling of inquiries by reporters so that these calls are referred at once to the person delegated to deal with them.

To maintain the standard of service wanted, there must be sufficient personnel to operate the board. The operators must receive adequate instruction from the chief or senior operator and the visiting P.B.X. supervisor concerning the mechanical operation, while a member of the administration should meet with them, perhaps every two months, to emphasize good public relations.

Switchboard operators work under nervous tension; hence, their shifts should include rest periods and should be shorter than in other lines of work. Because the quality of the service suffers when the remaining staff carries on without help in case of absence, "extras" should be available for relief when needed.

A good staff of operators needs adequate equipment. Ask the telephone company for a periodic traffic count. The report may show that the hospital is losing considerable good will because callers frequently encounter "busy" trunk lines. Or perhaps they wait too long because the operators are struggling with an outmoded system for locating personnel. Several large hospitals find it advisable to have a separate locating desk, thus freeing the switchboard for its main function, that of making connections. Additional mechanical facilities can often do much to ensure a prompt attentive welcome to all who ring at the "second front door."

How to Obtain Necropsy Permits

WILLIAM A. BRYAN, M.D.

THE scientific efficiency of the modern hospital is judged to a considerable degree on the basis of the necropsy rate. This is as it should be. It is only by careful study and analysis of disease that new facts will be obtained to assist the clinician. It is essential, too, that these examinations be made for the training of younger men.

A high percentage of necropsies means more than interest and enthusiasm on the part of the clinical staff. What it really indicates is that the relationship between the hospital and the patient's relatives has been so cordial during the period of illness that the family will follow the recommendation of the physician without question. Necropsy percentage is in direct proportion to the confidence and good will built by the institution in the community.

Confidence that leads to necropsy permits comes only as the result of good service. This service must be more than mere medical and surgical efficiency. The hospital that practices the science of medicine and neglects the art is not building good will. It may cure patients but it does not make friends, and if it does not make friends it will soon have no patients to cure. To practice the art of medicine means that every point of contact between the institution and those who patronize it must be carefully scrutinized by the administrator to ascertain whether the organization is making friends or enemies.

Real service means courtesy to visitors at all times; it means doing many things that are out of the routine but that add to the comfort of both patient and family. It means putting aside one's selfish desires and thinking in terms of the hospital as a whole. It means that an atmosphere of friendliness and sympathy must spread throughout the group. The creation of this feeling is the direct responsibility of everyone in the institution from the administrator to the kitchen helpers.

Doctor Bryan is the superintendent of the Worcester State Hospital, Worcester, Mass.

If visitors are not given proper attention, and they certainly do demand a great deal, if they are treated in a brusque manner by telephone operator, information clerk, nurse or intern, no amount of professional skill will ever eradicate the bad impression. There is only one patient in the hospital to the visitor. Rarely does he make any allowance for the pressure of work or other mitigating circumstances. Visitors judge the organization by their own standards. The cause for refusal to grant permission to do a necropsy, in many cases, may be traced to some unfortunate experience the relative has had with some member of the organization.

People are frequently unreasonable —they may even demand the impossible—but in most cases there is nothing personal in their complaint. It is the only way they have to express themselves about a situation that cannot be changed. The hospital is the only tangible thing about which they can express their dissatisfaction with life itself. If relatives believe that the institution has shown more than a mere perfunctory interest in the patient and if all those with whom they have come in contact have exhibited a spirit of sympathy and kindness, the request for a necropsy examination will invariably be granted.

In a hospital in which the highest ideals of service as well as an attitude of friendly understanding prevail, relatives see in the request a real desire to add to medical knowledge in order than others may be benefited. Thus, the high percentage of necropsy permits is in some ways the final test of the attitude of the hospital. If the members of the organization have been kindly, sympathetic and courteous and if the general atmosphere is right, the relatives will credit the physician, as the representative of the hospital, with the best of motives. But if they have received the impression that the hospital is a cold, calculating, scientific machine, the request will probably be refused.

Plan First, Then Plant

HELEN SWIFT JONES

A GENEROUS expenditure of money and effort for landscaping the grounds of public or private hospitals may be entirely justified or it may be, as it is often considered, "wicked extravagance." Whether it proves to be the one or the other depends largely, if not entirely, upon two factors.

First, before starting work, there should be a clear conception of what is really needed by the particular hospital, as well as what is possible of attainment. That is, there should be a plan. As twin sister to this plan there should be a carefully conceived program for consistent care and upkeep.

These two factors cannot be overemphasized at the start, for the hazards of waste and failure are greater in landscaping than in building or interior decorating. This is true partly because, although gardening is almost as old as the human race, modern landscaping is not as well handled as are the older professions of architecture and interior decorating. It may also be due to the fact that living (hence dying) material forms so important an element in the work. It is easy, too, to put the "cart before the horse" in landscape work, and this alone may mean many dollars worth of labor and materials thrown away, a fault that can be largely avoided by experienced forethought. Consequently, a plan should be an absolute requisite before a single yard of soil is moved or a plant bought, if the work is to be accomplished successfully.

Too often a little money is wrung from the treasury or donated by a kind patron to "fix up the grounds" or, because gardens are the height of fashion, "to make a garden," whether it will be worth its cost to the patients or not. The responsibility of having the work done is turned over to a willing member of the board who, perhaps, has had experience with his or her home grounds. A nurseryman is called in and, to the delight of everyone, a gang of men is soon on the job. It is no wonder that the results are so often a liability to the hospital authorities and become an increasing source of expense and worry.

Hospital landscaping is a problem of what can be done to the grounds, the backyard alleys, roofs, courtyards and even window sills, to bring to the patients as much of the outdoors as possible, for growing things are a source of rest, relaxation and distraction from the suffering and unhappy thoughts of the sick.

Every hospital will have different problems, depending upon the needs of its patients, the extent and type of its property and the kind and amount of upkeep available. It is, therefore, wise to plan something

Miss Jones is a New York landscape architect.

Above: A view of the garden of the Avery Convalescent Hospital, Hartford, Conn. It is no wonder that patients refer to the hospital as "the country club." The garden was laid out with play and rest areas comfortably accessible to the hospital. Right: One of the wood walks around the grounds of the hospital. Patients and visitors have a wide view over the city of Hartford from this point of vantage.

It is difficult to believe that this charming roof garden is on top of grim Bellevue Hospital in the heart of New York City. The roof is divided into three sections: one for play, one for rest and one for gardening. The garden area contains boxes and tubs of shrubs and plants, as well as a vegetable garden that is extremely popular with the children.

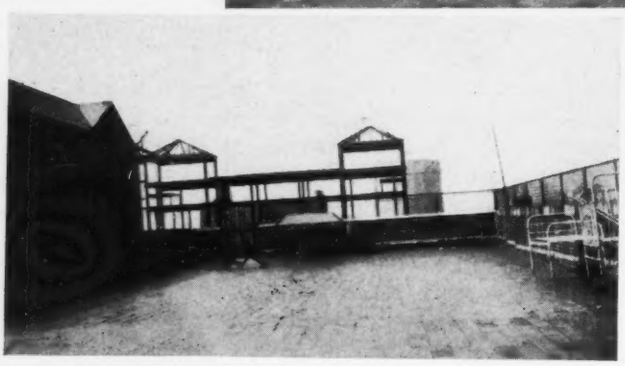
simple and to know that there will probably be adequate funds for care rather than to accept the most enchanting scheme of developments as a gift, but with no provision for future care. Landscaping will be of lasting value to a hospital only if it is able to play its part in the recovery of the patient and has been so planned that it does not become a burden to the organization.

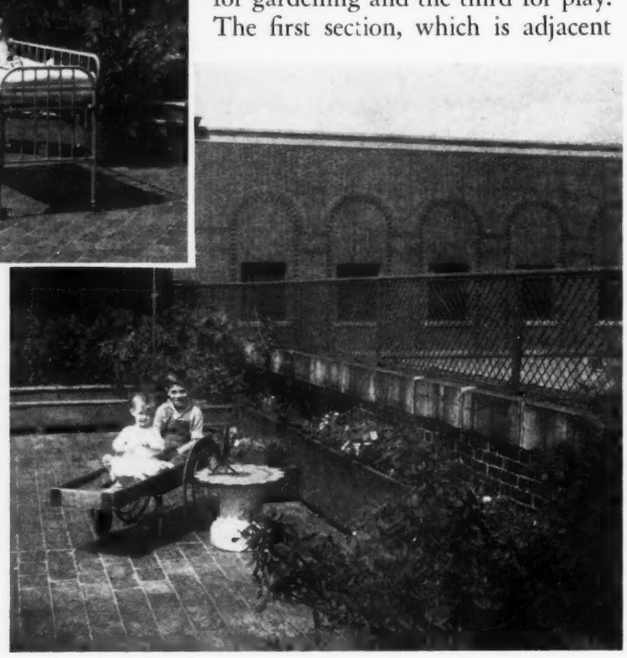
What can be accomplished even during difficult times is well illustrated in the following examples of landscape work. In each case plans were made before one cent was put into labor or materials. All of the hospitals mentioned have been built during the last ten years.

The plan and landscaping of the roof garden and playground for the orthopedic ward at Bellevue Hospital, New York City, was given by the National Plant, Flower and Fruit Guild as a memorial to its founder and first president, Mrs. John Wood Stewart. Money was raised for the preliminary work by a few member clubs and the plan with its varied features is gradually being completed as other member clubs become interested and ask to share in the gift. It has proved the greatest joy and comfort to both the children and the nurses and it is hoped that it may be an inspiration to garden groups in other communities.

The roof lies directly outside the ward and faces south; it was divided into three areas, one for rest, another for gardening and the third for play. The first section, which is adjacent

Below: The snapshot shows what the roof of Bellevue looked like before it was transformed into a combination garden and playground.



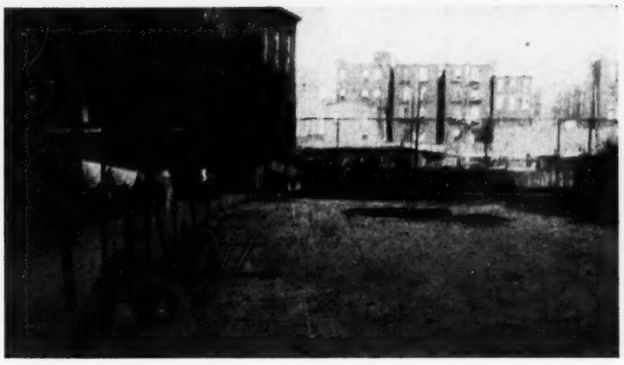


BEFORE PLANTING WAS BEGUN

The garden of another hospital in the center of New York, the Prospect Heights Hospital. It was designed to form an oasis on which the patients could look down from their windows. The use of evergreens lends interest to the garden in winter.

to the ward, is covered with an awning and is shut off from the second by an evergreen hedge. Cots can be easily rolled out here for naps in the air, and quiet games are played when the sun is too hot for the open sky.

The second division, surrounded by an evergreen hedge, is the garden area and contains permanent boxes and tubs of shrubs and plants, as well as boxes in which the children can plant and care for marigolds, zinnias, petunias, bulbs and, what are even more popular, radishes, carrots and tomatoes. Cutting a few flowers for the ward each morning has become a ceremony loved by the



Right: One of the tree-lined walks on the grounds. It leads to a vine covered pergola at the end of the garden. Below: A "before" snapshot of what is now the garden at Prospect Heights Hospital.

Clock golf is one of the favorite pastimes at Avery Convalescent Hospital.

children and appreciated by the nurses as an added event of the day.

The area farthest from the ward is arranged for such play as is possible. A sandbox, play house, swing and other distractions keep the little patients contented and happy.

St. Luke's Home for Old Ladies, also located in the metropolitan area of New York, turned a dark and dreary city backyard into a garden that not only created "a place to go," but shut out much of the surrounding ugliness with its high walls and fences. Planned and executed with an understanding of which plants are best able to survive city conditions without too much care, and with a regard for the cost of upkeep, it has proved well worth its cost.

The garden at Prospect Heights Hospital, another institution in the heart of the city, was designed especially to shut out the city sights and sounds as much as possible. It was planned to form an oasis, a spot lovely to look down upon from the patients' windows throughout the year and a peaceful corner where families might wait in the sympathetic atmosphere that nature and beauty evoke. Tree-lined walks along two sides and a vine covered pergola at the end of the garden give shade during the summer months, while the use of many evergreens lends interest during the winter.

To meet the need of the patient who no longer requires complete hospital care but who still is not ready to return home the convalescent hospital is gradually assuming new importance. One of these institutions is the Mary Ogden Avery Convalescent Hospital at Hartford, Conn., which is complete as far as landscaping for the patient is concerned. From their inception the buildings and grounds were harmoniously planned with architect and landscape architect called in to consult with the building committee. It is often called a "country club" by the patients who come from the Hartford hospitals, yet there is nothing elaborate in plan or upkeep.

The layout was made for convalescents with play and rest areas comfortably accessible to the building; walks with gentle slopes; plenty of seats in both sun and shade; drinking fountains, and a few quiet games, such as shuffle board, clock golf and croquet. Perhaps because it is a part of the house terrace and is easily reached shuffle board has been the most popular game. Maybe there is a psychological reason, too, because it is a reminder of carefree times on shipboard. However, these simple games have required a minimum of fussy upkeep and have proved a great source of diversion.

The planting on the grounds is mostly of native materials and even the garden relies upon a few long-lived plants, such as irises, peonies, chrysanthemums and daffodils. Because the hospital is a part of the public hospital system of Hartford, the park department cares for the grounds and this ensures a continuity of good care.

Landscape work requires constant upkeep to be worth its original cost; otherwise, it may rightly be considered an extravagance. Planless work is an extravagance for it invariably means greater expense in the future.

Every institution that appreciates the value of landscaping will find a way to meet costs just as those mentioned have done. In view of the tremendous interest there is in gardening of all kinds, auxiliaries of the hospital may be encouraged to raise money; garden clubs may add the hospital grounds to their program of civic work or, perhaps, grateful patients may wish to leave some tangible evidence of appreciation and will help financially if there is a definite plan prepared. To paraphrase an old saying, "Where there's a plan there's a way."

Administrator Rules Records

WILLIAM B. SELTZER

THE administrator plays an important part in the development and improvement of the medical records in his hospital. He is in a position to emphasize the importance of this service, especially in its relation to other departments of the hospital.

One of the most delicate problems that the administrator and the record librarian must solve is to enlist the cooperation of the chiefs of the services, who, instead of serving as a source of stimulation for the younger men, may share in their delinquencies. In order to reenforce and strengthen the procedure for the entire hospital, the administrator should require the medical board to set up simple but concise rules for the guidance of the staff in compiling records. Certain disciplinary measures should then be decided on for the enforcement of these rules.

Always a few members of the medical staff, mayhap the authors of the rules themselves, are of the opinion that the rules do not affect them. One regulation should provide that any physician who has not completed a medical record after a stated period of time will have his hospital privileges suspended. When the record is completed, the physician should be required to write a letter to the record committee or the medical board asking for reinstatement. It is obvious that these measures will bring about cooperation from even the most delinquent.

If a member of the staff is habitually neglectful in completing his records, he should be asked to resign. Such action will have a salutary effect upon others. Once these rules have been passed by the medical board, the administration must put them into effect and enforce them; otherwise, they are valueless.

The next step in this program of promoting good scientific records is to establish a record committee with a strong chairman. Every hospital staff has a few men interested in the problem of medical recording who are in a position to set an example by the good medical records in their own departments. Such men should constitute the record committee because, unless the members of this committee themselves stimulate good recording, they will have difficulty in obtaining the cooperation of the rest of the staff.

The record committee and medical board of one hospital have found it wise to enlist the younger men of the staff in promoting good recording. Young men frequently have the time, interest and ability to act in this capacity and will cooperate when given an opportunity to be active on such a program. While the usual procedure in hospitals is to staff these committees or subcommittees with attending physicians, this institution has found it more effective to ask the attending physician on each service to assign one of the younger men to the task of reviewing the charts on his service.

A committee to review charts meets every two weeks to discuss problems that have arisen and to make suggestions for the general improvement of the records. Both the record librarian and the hospital administrator are present at these meetings. The chairman of the record committee is also the chairman of this subcommittee. The work of the chart reviewers not only reduces the number of charts coming to the record room in incomplete form but also has the constructive effect of producing better and more satisfactory records from every point of view.

Records of ward cases are on the whole better than those of private patients, because, in the case of the former, the responsibility lies with the chief of the service. There is no justification for this lack of supervision of private records; they should be as complete and as scientifically thorough as those of ward patients.

The hospital administrator should encourage the members of his medical record staff to attain the professional standing of members of the American Association of Medical Record Librarians and should stimulate those who are not members to take additional training to meet the requirements of membership. The administrator should also encourage the staff to participate in the activities of the association and should make it possible for some of the record librarians to attend conferences of the association, particularly when they are held within a reasonable distance.

If we demand good scientific recording on the part of our staffs, it is essential that we provide them with the proper mechanical facilities and clerical assistance. Physicians should be provided with a comfortable room, adjoining the record room, where they may come to review and to complete charts. The record room should be located on the main floor and, if possible, near the doctors' staff room. It should be well equipped and pleasant in appearance. Above all, the record room should be staffed with well-trained

HOW DO YOU ANSWER THESE QUESTIONS?

1. Are rules for compiling records laid down by the medical board?

2. Are they rigidly enforced without fear or favor?

3. Are staff members provided with a well-equipped room wherein they may complete their records?

4. Is the record clerk a member of the record librarians' association?

5. Does she have authority to insist that records be completed?

6. Does the administrator appreciate the value of records and back up the record committee and the librarian?

Mr. Seltzer is superintendent of the Bronx Hospital, New York City.

record librarians, some of whom should be good medical stenographers. It is well, too, if such an arrangement is possible, to have the record room adjoin the medical library so that medical books may be conveniently available for the use of the physicians when they are working on charts. At the Bronx Hospital, New York, we have observed that, since the library has been moved to a more accessible location adjoining the record room, it is more frequently used by the physicians in connection with their record writing. If the record room is inconveniently located and is lacking in proper facilities, it is likely to convey to the medical staff the impression that the administration is not particularly interested in good records.

Some hospitals have difficulty in having records of operations dictated immediately after the operation is performed. This difficulty can be overcome in any hospital, regardless of its size, by having someone available in the operating room to whom the surgeon can dictate immediately upon completion of the operation.

Stenographers on Wards

The provision of stenographic service on the wards, particularly when weekly grand rounds are made, is to be commended. It has been found that medical records improve proportionately as this service is increased. Hospitals are beginning to recognize the value of dictating instruments, particularly for the use of interns and residents.

We have improved our private obstetrical records by sending a letter to the patient's physician as soon as she enters the hospital, informing him that the patient has been registered. The physician is also sent a copy of our prenatal record form on which to record his findings. In this way, our obstetrical records are kept uniform for all patients. The obstetrical supervisor sends a daily report to the administrator listing the patients delivered that day, the type of delivery and indicating whether the prenatal record was attached to the chart and the labor record completed. We have approximately 2300 deliveries a year, and in 95 per cent of these cases the prenatal record is attached to the chart before delivery. The record librarian reviews the daily report of the delivery room and sends a letter to each physician who did not fulfill this requirement, advising him of the hospital regulation and requiring him to file his patient's prenatal record within twenty-four hours.

Reports on Incomplete Charts

A problem that faces many record librarians is how to reduce to a minimum the number of incomplete charts of both house and visiting staff. The responsibility for following up the physicians should not be left entirely with the record librarian but should be assumed in part by the administrator.

The administrator should receive a report weekly, biweekly or more frequently, if necessary, listing the number of incomplete charts of each member of the house staff. The list should contain the number of charts that have remained incomplete for more than twenty-four hours, more than two days, more than one week and more than two weeks so that the administrator can easily see how many incomplete charts there are and how long they have been incomplete. He will then have concrete information upon which to act. The same type of report should be made by the record librarian regarding incomplete charts of the visiting staff.

Our record room sends a post card to each man on the staff who has an incomplete chart for a period longer than three days. If the chart is not completed at the end of one week, another post card is sent. If at the end of two weeks the chart still remains incomplete, a letter is sent by the administrator stating that if the chart has not been completed by a stated date (within five days) the physician's hospital privileges will be withdrawn.

With this type of control, the number of incomplete charts can be reduced to a great extent, and the length of time the charts remain incomplete can also be reduced considerably. Furthermore, this method eliminates considerable loss of time and duplication of effort on the part of the record librarian. The members of the staff know that the administrator is giving the record librarian the necessary support and that failure to complete their charts promptly will be followed by disciplinary action.

It is important that surgical cases be completely worked up before the patient goes to the operating room. The record should include a complete history, physical examination, blood count, urinalysis and the surgeon's preoperative diagnosis, in addition to the preoperative diagnosis made by the house surgeon or resident. The question has often arisen as to which member of the operating room staff should be responsible for seeing that such data are recorded on the chart. In some hospitals the responsibility has been delegated to the operating room supervisor. Difficult situations may be created when it is necessary for the operating room supervisor to tell a surgeon that he cannot operate until the record is complete. It is much better to have this responsibility delegated to a physician.

Completing Surgical Records

At the Bronx Hospital, all anesthetics are administered by physician anesthetists, and the anesthetist is responsible for seeing that the cases are worked up and that the necessary information is recorded on the chart. The anesthetist may not proceed with the administration of the anesthetic unless the case has been properly worked up. If the surgeon states that the case is an emergency and that he must proceed with the operation despite the lack of recorded information, he is required to sign a statement on the chart to the effect that he is aware of the fact that the blood count, urinalysis, history or physical examination is not recorded on the chart and that he assumes the responsibility for this omission.

At first, a few surgeons elected to sign this statement on the chart but they soon realized the responsibility they were assuming in adopting this practice. If anything happened to the patient and they were sued for malpractice, this statement with their signature would furnish damaging evidence against them. We now find that the surgeons do not care to sign the chart in this way, and their only alternative is to see that the case is properly recorded.

Volunteer Blood Donors

ALBERT W. SNOKE, M.D.

THE use of blood as a therapeutic agent was first presented by Landsteiner in 1901. Since that time hospitals have been faced with the problems of obtaining, typing and administering blood as promptly and efficiently as possible.

In recent years, in an effort to provide a satisfactory answer to these problems, such methods as the use of "blood banks," lyophilized serum and cadaver blood have been tried. The "blood bank," in particular, has been moderately successful in some communities.

On Oct. 9, 1939, over a national hookup of the National Broadcasting Company a dramatization was presented of yet another means of obtaining blood: through the medium of a volunteer legion of blood donors. This broadcast was not initiated or participated in by the hospitals but was presented primarily from the standpoints of the broadcasting studios and of the volunteer blood donors. It is in response to numerous inquiries that an analysis of this plan from the viewpoint of the participating hospitals is presented.

The Legion of Blood Donors was started March 18, 1937, by Al Sigl, newscaster of the *Times Union*, an evening newspaper of Rochester, N. Y. It was originally planned to provide blood donors for local patients who either could not afford to purchase blood or who required emergency transfusions. The organization has now spread so that many small communities surrounding Rochester have local groups of volunteer donors serving community hospitals.

Prospective blood donors in Rochester apply to Mr. Sigl and are sent by him to near-by hospitals where their blood is typed and a Wassermann test is taken. The report of the blood type and the results of the test are sent to the central office where the donor list is maintained with addresses and telephone numbers. There is twenty-four hour service because this central office is associated with the newspaper; consequently, donors may be obtained at any hour of the day or night. When a request for a donor is received, an individual in the region of the hospital is notified and he goes directly to the hospital. Through an arrangement with the police department, a cruising patrol car will take the donor to the hospital, if necessary; occasionally a taxicab is sent.

The volunteer groups in the communities surrounding Rochester usually are formed with the local hospital as a nucleus. A sponsor, such as the local service club, volunteer fire department or sheriff's office, assumes responsibility for organizing the volunteer group and providing transportation to and from the hospital. Volunteer donor lists are furnished the community hospital by the sponsor and the hospital calls the donors directly. The central office in Rochester is used only for unusual requests.

The advantages, as well as the hazards, of a volunteer blood donor service are set forth in this article, which describes the highly successful method of handling such a service worked out for Rochester, N. Y.

Volunteer blood donors are usually called by telephone. However, in emergencies, or if the call comes in near the time of one of the scheduled news broadcasts, it frequently is announced over the radio that a specific type of donor is needed. Originally the name of the hospital requesting the donor was given. The disadvantages of this method quickly appeared; as soon as the request was broadcast, the hospital switchboard would be deluged with calls from volunteer donors, typed and untyped, and from individuals who were merely curious as to what was going to happen to the patient. Now the radio announcer simply asks that one or two individuals who are of the specified type call the newspaper office. From the many calls that come in from the volunteer group one donor who is near the hospital is selected.

The hospitals have assumed the responsibility of seeing that the volunteer blood donors are not imposed upon and all calls to the newspaper office from hysterical relatives are referred back to the hospital. Calls for donors are cleared through the admitting offices of the hospitals. The doctors and resident staff are instructed that this service is to be used only for emergencies and for patients who are unable to provide their own donors. Thus, every effort is made to obtain donors from the relatives or friends of patients or to employ professional donors if the patients can afford them before a call for volunteer donors is placed.

Every effort is made to facilitate the transfusions as much as possible because many of the donors are housewives with children at home or are working men whose employers have given them time off to come to the hospital to donate their blood. If the transfusion is an emergency, the cross-matching and emergency Kahn test are done immediately and the blood is taken as quickly as possible.

If the transfusion is elective and no great emergency exists, this information is given the newspaper by the hospital when the request is made. In these instances, the donors come at their convenience, the blood is typed, another Wassermann is taken and the arrangements are made for returning the next day at a convenient time for the transfu-

Doctor Snoke is assistant director of Strong Memorial Hospital, Rochester, N. Y.

sion. The latter procedure is frequently used when a patient requires a series of transfusions or when blood is required from individuals who have recovered from specific staphylococcic or streptococcic infections.

The legion has been operating for two and a half years. During this period more than 2500 individuals have been typed and placed upon the donor list and 970 blood transfusions have been given. Although the plan has certain disadvantages, it has proved of such definite value to the hospitals of the area that a distinct loss would be felt if it were discontinued.

Probably the greatest value of the legion is that it provides the hospital with a readily accessible source of blood donors of all types. It is difficult for a hospital to have a number of individuals of different types available for donors unless there is a large number of employes or medical students from which to draw. The average hospital, particularly in the smaller community, is frequently hard put to obtain blood in emergency cases. This difficulty in obtaining blood quickly has been one of the main reasons why blood banks have been established. Unfortunately, blood banks do not appear to be the answer in small or moderate sized hospitals because they are expensive to establish and maintain and may not be successful unless the turnover and the number of transfusions given are reasonably large.

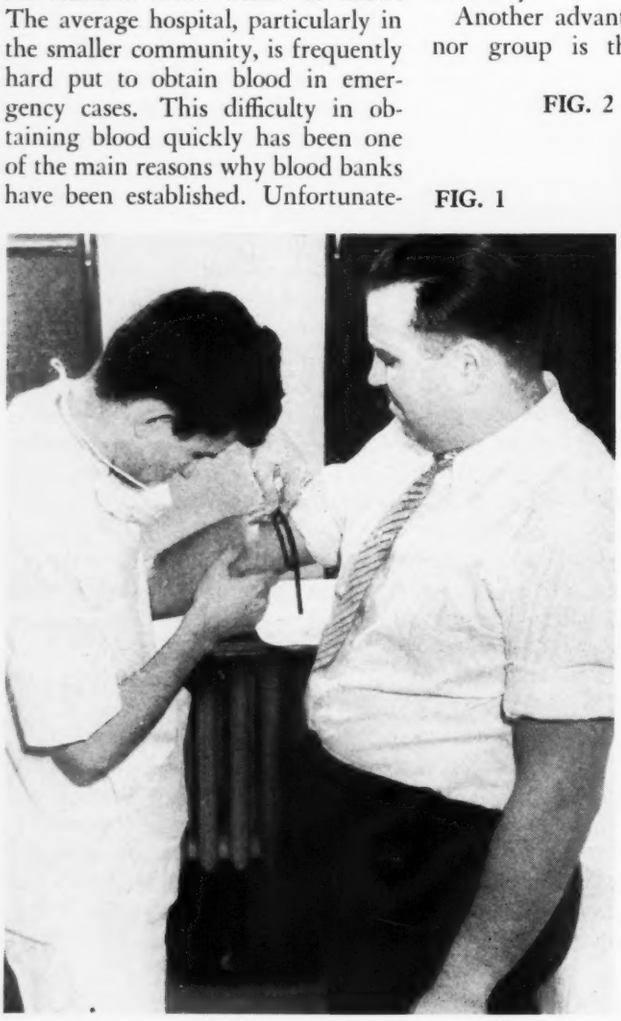
Large hospitals situated in small communities and drawing patients from large areas will probably find little value in a voluntary blood donors' organization. In these areas the number of volunteer donors may be inadequate for the number of transfusions required. For these institutions, as well as for large hospitals in urban areas, blood banks are probably more satisfactory. However, it is of interest to note that one hospital in the Rochester area that is large enough to warrant establishing a blood bank decided against it, largely because the service rendered by the volunteers was so efficient that the blood bank was not necessary.

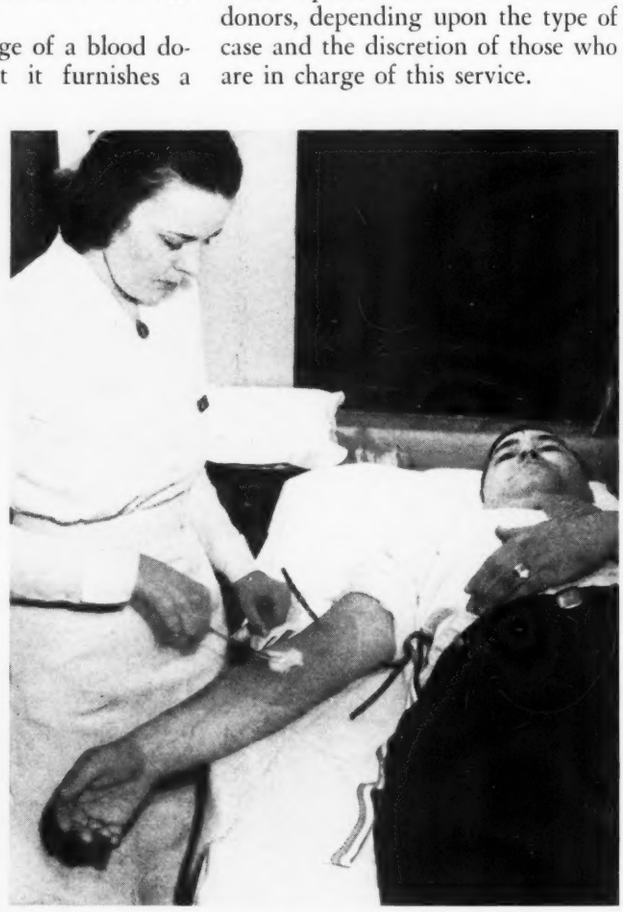
Another advantage of a blood donor group is that it furnishes a source of blood at little cost to the hospital. As a rule, when a blood transfusion is necessary for an indigent patient, the hospital must pay a professional donor if relatives or friends are not available. Thus, marked savings can be effected in city and community hospitals by obtaining free blood for purposes of transfusion.

To a great extent the blood transfusions given by the volunteer group have been free. People have enrolled with this understanding and, as has been previously stated, these individuals are called only when a patient cannot pay. Occasionally, when a patient is able to pay for the blood and no satisfactory professional donor is immediately available, the head of the volunteer organization is told of that fact and asked to send some deserving individual who needs the money. It is possible that a volunteer group could be organized to furnish professional as well as free donors, depending upon the type of case and the discretion of those who are in charge of this service.

FIG. 2

FIG. 1





A volunteer blood donor being prepared for the transfusion. Fig. 1: Intern searching for the vein. Fig. 2: Nurse preparing the arm before the blood is taken from the donor. Fig. 3: Taking blood from the vein.

The Legion of Blood Donors has also been found of value in enlisting donors with high titers of protective antibodies. Individuals recently recovering from streptococcic or staphylococcic infections or measles enroll as volunteers and furnish blood when necessary. Occasionally, calls for such individuals are received from hospitals 400 miles away. Requests for type 3 donors are also easily filled because of the number of such volunteer donors available.

Another advantage that is intangible, but no less real, is the feeling of service that the volunteer blood donor has from giving the blood for a transfusion. Blood transfusions are still considered by the public as spectacular procedures of life-saving value and no amount of cynicism can deny the fact that many people will feel an emotional sense of service in helping a sick patient by giving him blood. If dealt with intelligently and efficiently, the blood donor feels that he has been of service to the hospital and the community. It may be considered as an additional means of getting the average citizen to be more conscious of the hospital's rôle in the community. Because of the emotional appeal of giving one's blood without pay, careful thought should be given to the inclusion of professional donors in a volunteer donors' plan. It is doubtful whether a volunteer group should be used to replenish the stock of a blood bank. There is no glamour in giving blood to a bottle.

It has been suggested that this feeling of having given something to the hospital and to the patient may work to the disadvantage of the hospital as the volunteer donor may expect favors in return. This has not been the experience of the hospitals in the Rochester area.

Although the Legion of Blood Donors has been very satisfactory in the experience of these hospitals, it should be mentioned that the success of this plan has been almost entirely dependent upon the enterprise and enthusiasm of the originator. Mr. Sigl has devoted a great deal of time to this project and has endeavored to keep personally in contact with all volunteer donors. Whether there would be interest among the donors if he were not running the plan is questionable, and whether such a project would be as successful elsewhere without a similar organizer, who would regard it as one of his hobbies, is a debatable question.

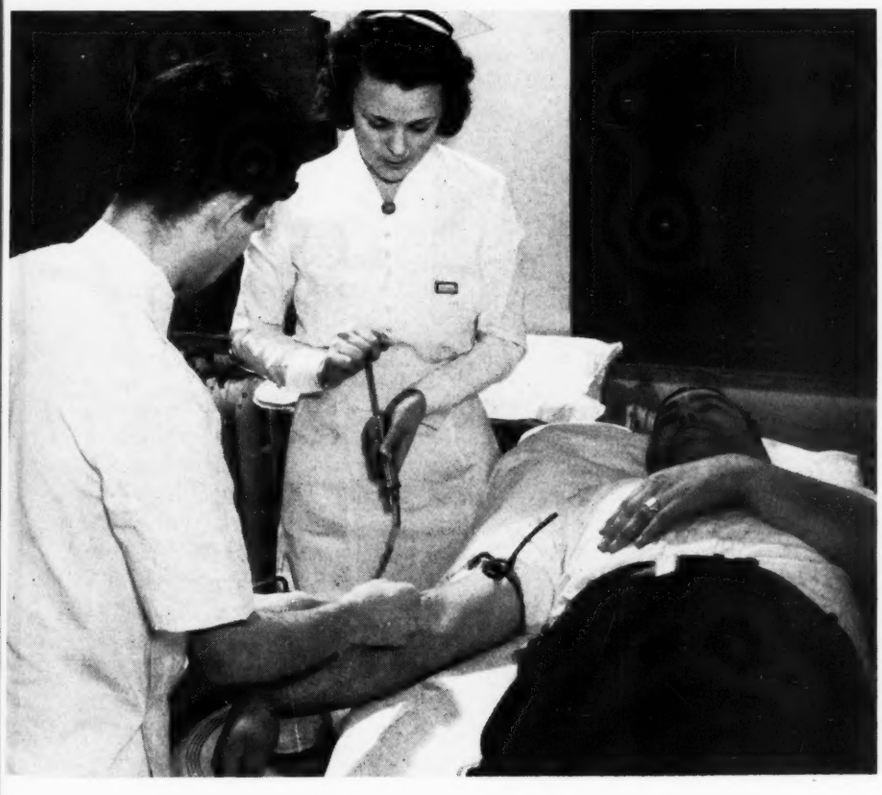
It is also desirable that there be discretion in the choice of patient to whom free blood is furnished. Too often newspaper articles are published about individuals who donate blood to patients with fatal diseases. Although people are eager to donate their blood with the hope that the patient may recover, volunteer blood transfusions for such diseases as subacute bacterial endocarditis, leukemias, erythroblastic anemia and other apparently hopeless conditions should be strongly discouraged.

Taking the blood of volunteers for such conditions is an exploitation of the donors. It is also unfair for hospitals and patients to accept blood from donors as a matter of course. Too often the donor is not even thanked. Some of the Rochester hospitals have instituted a personal letter or card to be sent to each volunteer donor, thanking him for the blood given.

The association of a newspaper and a radio broadcasting station could result in unsatisfactory publicity and promotion stunts that would do a great deal more harm than good.

The fact that this plan has not suffered from such experiences is due largely to intelligent management by the sponsor. Careful control of patients who employ the donors and of the methods by which the donors are selected, typed and sent out for transfusions must be exercised by the hospitals and physicians in cooperation with the agency that sponsors the group.

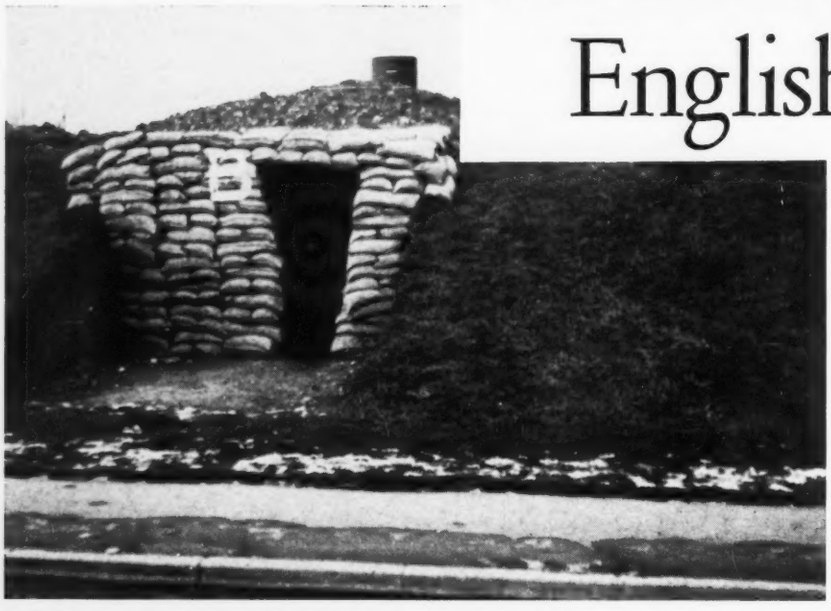
FIG. 3

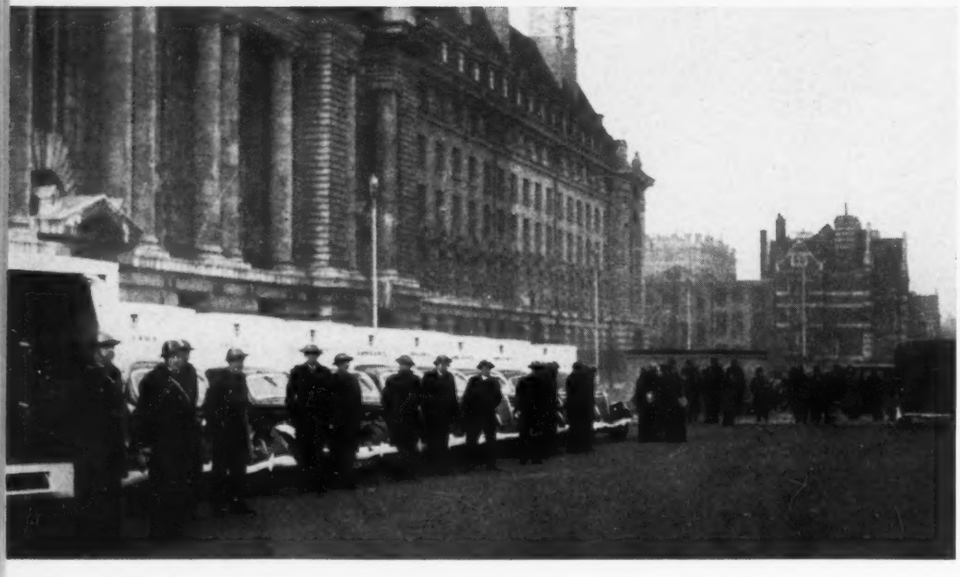


"Business in Heaven"

Most people like to do business in heaven. Few legacies are left to charitable institutions to be used for whatever purpose seems most necessary at any time from an administrative or scientific standpoint. All too often the legacy must be used for some specific purpose of secondary importance, simply because the testator so decreed. This is another kind of philanthropic hobby that the world of charity might reconsider.—HENRY L. MOSES, *president, Montefiore Hospital, New York City.*

Right: A closeup view of one of the women's ambulance units of the London County Council. All of the light units are staffed by women. Center: One of the bombproof dugouts to which the nurses are assigned in case of an air raid. Below: One of the men's heavy ambulance units drawn up for inspection.





English Hospitals

A. G. STEPHENSON

THE organization of English hospitals on a war footing is extraordinarily efficient and complete to the last detail. All hospitals are now under the direction of the Ministry of Health. In accordance with a prearranged plan, each major city is divided into sectors from its center outward and more than 75 per cent of the patients have been transferred to safer areas. The city of London is divided into ten sectors, each of which radiates from the center of the city to a "safe" area.

Hospitals of each sector are divided into three main groups: (1) casualty clearing hospitals, comprising the voluntary and municipal hospitals from which most of the patients have been transferred; (2) advance base hospitals, and (3) safe area base hospitals. All of the sick and injured who could be moved have been transferred out of the danger zone and a great many beds have been made available for emergency treatment in the event of attack from the air. The hospitals in each sector are all staffed from the inner London hospitals and are

equipped largely from their resources insofar as x-ray and special medical equipment are concerned. Beds that are considered suitable for emergency purposes have not been transferred.

Each sector has its own director and deputy and is organized as completely as possible in every branch. Normally there are more than 80,000 hospital patients in London and, although I was not able to obtain actual figures, it would be safe to estimate that 75 per cent of this number have been evacuated to the hospitals in the outer areas.

Long before this war broke out the scheme of evacuation was prepared and a survey made of the available bed accommodations in each sector. On the theory that the arrangements would be a temporary expedient, a series of alterations or

in War Time Dress

of Stephenson and Turner, Architects
Sydney, Australia

enlargements to existing institutions was undertaken, and only one completely new emergency hospital was erected. In some cases it was possible to adapt mental hospitals for the purpose. Large residences and other institutions were transformed into hospitals to meet these emergency requirements.

The beds thus vacated in the inner London hospitals were classified according to the ability of the hospital to withstand bombardment. For instance, a new institution constructed of steel and reenforced concrete would be allotted the full complement of beds on all but the top floor. Older hospitals would be rated at 50 per cent or less in capacity because of their construction and ability to resist attack. Each of these inner hospitals has an area adapted for a large casualty clearing station and is permanently staffed and equipped for the purpose. Each station is equipped for the reception of casualties and includes operating rooms, cubicles for rest and observation, a clearing station for ambulatory patients and bed accommodations for serious cases pending their transference to an outer area.

Judiciously located throughout the inner areas are gas decontamination stations for use in case of bombardment with gas bombs. Every care has been taken to fit these stations as efficiently as possible. Patients who have been gassed will be hurried to these stations, their clothes will be removed, they will be given hot and cold douches and they will be examined, treated and, if necessary, transferred to a bed in hospital. Ambulatory cases will be fitted out with spare clothes until their own are returned to them.

Lambeth Hospital, which normally has a capacity of 800 beds, is of the old type but, nevertheless, is well administered and equipped and is located in the center of a thickly populated area. Here 500 beds are set aside for air raid precaution needs. Ward after ward is maintained in a spotless condition; rows

Above: The ambulance drivers must be skillful to negotiate the sandbagged entrances to the hospitals. Below: All of the hospitals in London have the doorways and entrances barricaded with screens of sandbags as a precaution against air raids. White lines outline the sandbags so that the entrances can be seen after dark.

of empty beds are neatly covered with green counterpanes and white pillows, ready for the day that it is hoped will never come. These hospitals may, of course, be used for military casualties if they are not required for air raid purposes.

Ambulance services are most efficiently organized and come under a central control. Each sector has its own service, which is manned by both women and men drivers. The lighter ambulances are in charge of women, and only the largest ones are staffed by men.

It is hard to visualize the problems that arose in this wholesale transfer of patients from the inner London hospitals. An average of 35 nurses to every hundred patients and a proportionate number of other staff members were transferred at the same time. A sufficient staff was selected to remain in the central hospitals to cope with the patients remaining and to form a nucleus in case of emergency. This nucleus comprises doctors, nurses and wardsmen, in addition to both clerical and lay staff. They stand by for eventualities, train others and increase their own efficiency while waiting.

In the outer sectors it was found that there was a shortage of accommodations for nurses and staff in or near the hospitals to which their patients were transferred. This necessitated billeting nurses in private establishments in each community.

The first hospital I visited in London was the new Children's Hospital in Great Ormond Street. The nurses' home and the main hospital, which is designed to contain 326 beds, have just been completed and when the war broke out construction of the out-patient department was suspended. The lower ground floor of this section, however, had been completed and this is now connected with an Air Raid Precaution station and fitted up as a reasonably bombproof casualty clearing station. A 4 inch concrete bursting plate was constructed over the normal floor slab and the intermediate space filled with sand.

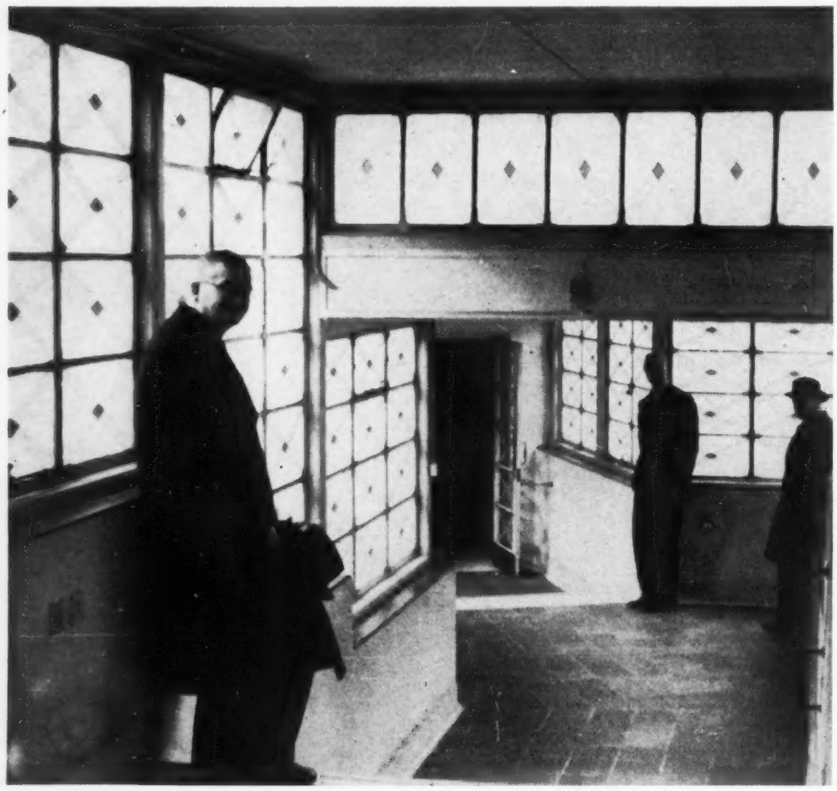
Only 50 patients are now in the hospital; the rest have been sent to other hospitals in outlying areas.

The entrances are barricaded with piles of sand bags; all light areas are piled high, as are all ground floor windows and openings. The windows above are pasted over with strips of tough paper or the glass is treated with a semitransparent tissue in order to minimize the danger of splintering. Heavy curtains are drawn over some of the glazed openings; others are simply painted black to avoid the possibility of light filtering through at night. The interiors are dingy or quite black without artificial light. Even with it, there is not much relief, for light and power have been reduced to a minimum.

It should be noted here that an A. R. P. wardens' post is located in each casualty clearing station. This applies to all large public buildings and many of the larger offices and stores. These posts are wrought iron, bell-shaped structures 5½ feet high, with a ring for lifting at the top. They are about 3 feet in diameter at the bottom and are fitted with two seats and a ⅜ inch slit at eye level for observation. They have telephone connections to the district headquarters and little gas tight doors. It is from these posts that wardens will direct operations in an air raid while being reasonably protected from falling débris.

All A. R. P. stations are protected with gas blankets, fire fighting apparatus and long handled shovels for shoveling up incendiary bombs should they penetrate to any combustible area. All casualty clearing stations are similarly equipped and attendants are trained to carry out their duties in gas masks.

The story of all the hospitals of inner London is just the same—there is no exception. It is particularly distressing to see the fine hospitals that have been recently completed, such as Children's, Westminster and the great new Medical Centre at Birmingham, thoroughly disorganized before they have been able to prove their undoubted value in the hospital world. Their makeshift departments, the dislocation of normal hospital procedures, the increased difficulties of finance and their staffing and teaching problems are all matters gravely affecting progress in the hospitals of England. But perhaps, from all these difficulties will emerge a better understanding of the hospital problem.



Windows are treated with strips of tough paper to prevent splintering.

Are Budgets Buncombe?

LEROY P. COX, C.P.A.

THE question has often been raised as to whether a budget system is of any value to the small hospital. It has been argued that in small hospitals money is spent for necessary items only and that it is impossible to keep within a budget. Such arguments are usually sound. Once the budget is set up, however, it is surprising how much effort alert department heads will make to keep their expenses within, or even below, the figure established.

The cost of making up a budget is small and certainly indicates a businesslike attitude on the part of the administrator that is gratifying to the trustees. Preparing a budget for the year should take no more than from one to four hours and if the administrator cannot make up the cost of the budget by the savings effected later, the hospital is already perfect.

Based on Three Year Average

Probably the simplest way to set up the budget is to establish it on the basis of the average departmental expenses for the last three years. Each department, as well as the subdivisions of each department, should be listed on a four column pad. For example, such items as salaries, telephone and telegraph and office supplies should be entered under the heading "Administration." The first money column should contain the expense figures for the previous year for each departmental subdivision.

The second column should show the average for each subdivision for the three years. The third column is the budget figure for the subdivision and should be a common sense estimate of the probable expenditure, based on the actual figure of the preceding year and on an average of the last three years. Any prospective change for the new year should be considered. The estimate should not be too high inasmuch as no particular honor or advantage accrues to the administrator if he keeps expenses below an excessive estimate. The fourth column of the page is to be used for remarks or comments.

On another pad of four, or preferably eight, columns, the name of first month of the fiscal year should be placed in the left hand, or name, space. The succeeding months should be entered in alternate spaces down the length of the page leaving a vacant line after each one. Most columnar pads have enough vertical lines to permit the entering of two sets of figures.

One twelfth of the annual budget estimate should be allocated to administrative salaries and entered accordingly under the proper heading. If the pay roll is increased during the vacation season, slightly less than one twelfth of the budget should be allowed for nonvacation months, with a proportionate increase for the vacation months. The total for this column should equal the annual budget figure for salaries. The lines that were skipped should be filled in to show the accumulated total at the end of each month.

The first skipped space, for example, will show the total for two months and the second, the total for three months. The next money column should show actual expense for the proper month and is to be filled in as the figures become available. The accumulated totals for actual expenses should also be shown.

The third column should show the next item, or subdivision, on the budget and should be broken down into months. The fourth column will show actual expenses incurred as they become known for this item or subdivision. This procedure should be continued until all expense items on the budget have been set up. Such items as fuel and ice should be considered as the seasons warrant. A larger amount of money will naturally be needed for fuel in winter than in the summer months. Consideration of the previous years' expenses by months is of assistance in arriving at approximate figures.

After the budget breakdown by months has been obtained, the administrator will be able to show some results for the time and effort spent in working it out. For example, if the actual administrative salaries figure is in excess of the amount estimated for one month or accumulated months, the situation can be investigated promptly. If there is a proper reason, nothing can be done; if some added expense has been incurred without reason, however, it can be stopped at once without waiting until the end of the fiscal year when an accumulated extra expense shows up.

Budget Checks Expenses

An increase in the number of patients for the current year may be a good reason for an increase over the budget figure. Here again, the budget proves useful because a 10 per cent gain in patients ordinarily will not produce more than a 5 per cent increase in the actual expense figure. Some departments will show no appreciable increase in expense unless the increase in patients is extremely large. If an unreasonable increase in expense is shown over the budget estimate, then the department head has probably become excited and has employed too many people or purchased unnecessary equipment. This often happens when the census steps up.

A useful procedure is to give the department heads a copy of the sections of the monthly budget that affect their departments, and to tell them that any increase must be explained. If expenses are decreased, the department head should be given credit for it, but care must be taken that this decrease does not lower the quality of care given the patient. If the department heads are given copies of the budget, the figures

Mr. Cox is superintendent of Woonsocket Hospital, Woonsocket, R. I.

must be reasonably low. Too high a budget may encourage increased expenditures.

Income figures are more difficult to obtain than expense figures. So many factors are involved that a fairly correct estimate is all that is possible. One cause of the difficulty is the fluctuation in the ratio of occupancy between free ward beds and private rooms. An increase in the occupancy of ward space, with a corresponding decrease in private room occupancy, will bring the net income down, even though the number of patient days remains the same. Returns from endowment investments, if any, can change quickly. However, if a reasonable approximation can be made, the possible deficit to be faced can be estimated and studied. Most hospitals can figure their incomes fairly closely on the basis of the experience of previous years.

It is of advantage to the hospital to have the probable deficit for the year worked out in advance so that the trustees and administrator will know exactly how much money will be needed when, and if, they appeal to the public for funds.

Support for Nonprofit Plans

ABRAHAM OSEROFF

THE activity of a hospital in furthering nonprofit group hospitalization does not end when it becomes a participant in such a plan. On the contrary a vast new field of endeavor is entered. The hospital, as a supporting pillar of the movement to broaden the scope of hospital service, is in a better position to carry the message regarding the nonprofit plan than is any other agency because the public instinctively looks to its hospitals, especially when the subject of community health is discussed.

It lies within the province of the member hospitals to spread the information that the institutions' part in promoting group hospitalization is of a positive nature in which the hospitals themselves foster the plan and are not content merely to extend treatment to the subscribers.

This is the motivating thought behind the approach of the Montefiore Hospital in Pittsburgh, which is a participant in the nonprofit plan of the Hospital Service Association of Pittsburgh.

The hospital has been most thorough in disseminating information regarding the plan. Nothing has been left to chance and, what is perhaps equally important, every effort has been directed toward making patients and their friends and relatives realize that the plan functions with the complete support and cooperation of the hospital.

That the action of the Montefiore Hospital has been productive of results is shown by the extent to which those who gained their initial knowledge of the plan at the hospital have returned for treatment when hospitalization was required.

To those administrators who desire to take similar steps, let it be emphasized that no complicated procedures are called for in order to achieve the desired results. However, a definite program must be mapped out and, although it should be relatively simple, it will require coordination and alertness. The various steps are so integrated that it is virtually impossible for anyone who has even the most casual contact with the hospital to escape acquiring some information about the plan.

A hasty trip to the bedside of a sick friend or even communication with the hospital by mail does not immunize one from knowledge of the service.

Placards attesting to the fact that the Montefiore Hospital is a participant in the nonprofit group hospitalization plan greet the visitor outside the hospital in the main driveway. These posters are enclosed in glass to protect them from rain and sleet. The lobby desk in the main entrance of the hospital contains literature. Similar material is available in the waiting rooms on the various floors. The emergency rooms have a supply and so have the out-patient department, the registration office and all other sections of the hospital that have contact with patients and visitors.

Employes are instructed how to discuss the more pertinent points of the plan so that they can converse intelligently with patients and visitors. It is important to add that no employe attempts to explain the service in detail. They are all instructed to discuss the plan only in its general terms and to refer prospective subscribers to the headquarters of the Hospital Service Association in downtown Pittsburgh. The prime purpose of the employe contact at the hospital is to direct attention to the functioning of the plan and to stimulate interest in it.

A feature of this method of operation that is especially noteworthy is the practice of calling the service to the attention of various commercial firms and other organizations. This is done by enclosing literature in bills, letters and other communications sent out by the hospital to the many commercial houses with which it does business.

The success of such a publicity program depends entirely upon the manner in which it is handled. It must be conducted with tact and diplomacy. There must be nothing in the method that would even remotely suggest "selling" the idea. Some such question as "Are you a member of the hospital plan?" or "Have you seen one of these pamphlets?" usually is sufficient to gain the necessary attention. Invariably the overtures for more information are made by the visitors.

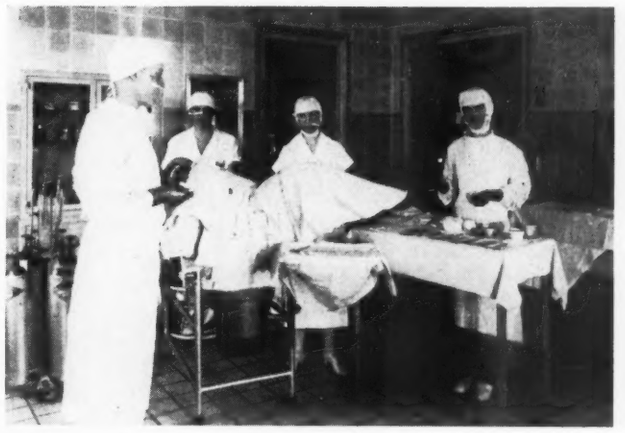
The employe then explains that the project is sponsored by the hospital and that patients who are hospitalized by the plan simply present a membership card upon entry. He adds that free choice of hospital is permitted.

Montefiore Hospital believes that similar action by all participating hospitals will greatly increase the total enrollment of the nonprofit group plans throughout the nation.

Mr. Oseroff is superintendent of Montefiore Hospital, Pittsburgh.

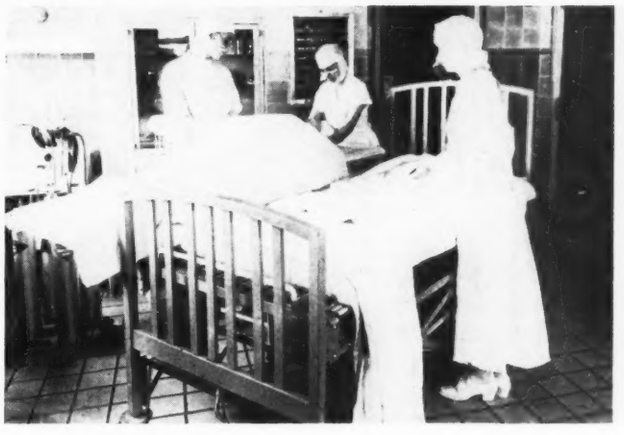
Nursing the Maternity Patient

CLARA M. KONRAD, R.N.



Right: In the delivery room, the scrub nurse watches the doctor closely and hands him the instruments as he needs them. No instrument that has been removed from the table is returned to it.

Above, left: The circulating nurse checks the packages of sterile dressings. Above, right: An infant is placed in the resuscitator. Right: Preparing to transfer the mother down to the postpartum room.



WHEN a maternity patient is considered ready to be taken to the delivery room, the labor room nurse notifies the delivery room charge nurse of the fact, wheels her patient in the crib bed to a room assigned by the delivery room charge nurse and transfers the chart and the infant's necklace to the delivery room. She assists in placing the patient on the delivery room table, awaits a signal from the delivery room nurse to go and then leaves, taking the crib bed with her.

The personnel of each delivery room consists of a circulating nurse, a scrub nurse and the attending physician.

When the patient is on the delivery table, the circulating nurse quickly checks once again to be certain that the forceps table is outside the door, with one of each type of forceps on it and that the resuscitator is also available. She inquires as to whether the patient is to have an anesthetic (which is always administered by the doctor) and, if a spinal anesthetic is to be given, places patient on her side, prepares the site and assists the doctor. The site of the injection is then covered with a sterile sponge and the patient is turned on her back. From that point all deliveries proceed in the same manner.

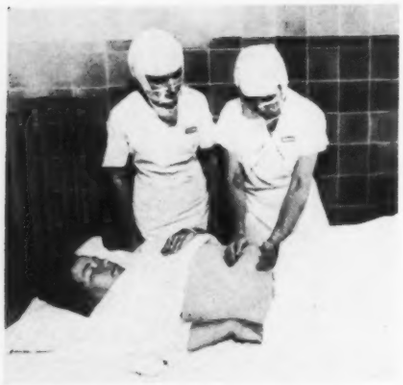
The patient is placed in lithotomy position, with buttocks well over the edge of the table; the circulating nurse paints the vulva, perineum and thighs. During this time the scrub nurse has completed her seven minute hand scrub. The circulating nurse uncovers the sterile table, while the patient is draped by the scrub nurse who arranges the triangular leggings, an abdominal sheet and four towels that completely encircle the field of delivery. She then hands the doctor four towel clips with which to adjust the towels.

The scrub nurse assists the doctor with the actual delivery. This begins with the catheterization of the patient, which not only prevents injury to the bladder but yields one sterile specimen for laboratory purposes. The scrub nurse watches the doctor closely, anticipates his wants and keeps uppermost in her mind the rule that she must never replace on the sterile table a single instrument or article that has been once removed from it. She is also conscious of the fact that she must remain sterile in order to assist him should an operative delivery or repair work be required.

While the scrub nurse is assisting the doctor, the circulating nurse has written the patient's name on a blackboard and records the progress of the case.

Immediately after the birth of the infant, the doctor holds it by the feet and gently milks the mucus from its throat with a downward

From an address to the American Congress of Obstetrics and Gynecology, October 1939. Miss Konrad is assistant superintendent and director of nurses at the Margaret Hague Maternity Hospital, Jersey City, N. J.



Holding the fundus is one of the important steps in postpartum care.

stroke. In cases that appear to be normal the buttocks may be lightly spanked. The infant's necklace, which has been boiled by the circulating nurse and placed at the corner of the sterile table, is now handed by the scrub nurse to the doctor, with the bead crusher. Before applying it, he calls the name on the necklace and the circulating nurse calls the name on the mother's bracelet and chart; if these correspond the doctor applies the necklace.

The next procedure is the application of a 1 per cent silver nitrate solution to the infant's eyes. This is not followed by an irrigation. The method of instillation is highly important. The doctor opens the lids with eye retractors; the lids are not touched, the retractors being placed on the loose skin above and below, and the scrub nurse then drops the solution directly into each eye from the paraffin ampoule, which has been sterilized in alcohol. The nurse knows that the greater the height from which she drops the silver nitrate, the greater the weight and chance for trauma; she, therefore, holds the ampoule as near the infant's eye as possible.

Following these important steps, the scrub nurse hands the doctor the cord clamps and scissors; the cord is clamped; either a Ziegler button or a cord tie is applied, and the infant is placed on its right side in a sterile heated crib in the position deemed advisable by the doctor.

The scrub nurse then holds the placenta basin into which the placenta is expressed and is ready to assist in repair work.

After the third stage of labor is over, the doctor examines the placenta and measures the amount of blood loss in order that this may be replaced immediately, by either transfusion or infusion, if the amount lost is sufficient to warrant such procedure. The doctor steps to the side of the patient and holds the fundus while the circulating nurse administers the oxytoxic unless contraindications cancel this order.

Footprints of the baby and thumb prints of the mother are then taken; the scrub nurse cleanses the mother's thighs and buttocks with warm sterile water; applies vulva pads, and is assisted in transferring the patient to a bed that has previously been placed outside the door by the postpartum nurse. The mother is placed in Trendelenburg position, her gown is changed and, covered with a warmed blanket, she is taken to the postpartum room.

In the postpartum room the routine nursing care is as follows: The patient is assigned by the charge nurse to a postpartum nurse, who checks to be sure that the patient is warm and is lying in a comfortable position. She then holds the fundus for one half hour—not a guessed half hour, but a half hour by the clock. No nurse is permitted to hold a fundus unless she knows exactly how to hold it and why she holds it. She knows that to be assigned to hold a fundus does not mean that she may meander around the department but that she must remain there, holding the fundus, and that in order to be released she must be immediately replaced by another nurse and then only with the permission of the nurse in charge. To hold the fundus she places one hand above the symphysis and with a deep pressure permits her hand to get well beneath the organ. With that part of the uterus fixed, the other hand then presses through the abdominal wall, the fingers reaching above and behind the fundus. In this manner the uterus is held in an effective grasp between the two hands. She retains this grasp throughout the half hour, at the same time observing the patient's condition. She pays particular attention to any unusual amount of fresh bleeding and to whether the uterus is becoming more firm or is relaxing.

Breasts are cleansed and then covered with sterile glassine paper.

If the fundus is firm and the bleeding is normal at the expiration of the clocked half hour, this nurse flashes a light for the charge nurse and notifies her of the patient's condition. The charge nurse then calls the doctor and if he finds the patient's condition satisfactory, he writes a discharge order and the patient may be transferred to the postpartum floor.

The postpartum nursing care also includes making the patient comfortable, rearranging the bedding, applying a sanitary belt after changing the vulva pads and cleansing the buttocks and thighs. No perineal care is given in the postpartum room.

Breasts are washed with sterile green soap and sterile water and rinsed with alcohol; sterile vaseline is applied to the nipples, and these are then covered with sterile glassine paper and a sterile breast towel.

This postpartum care, in normal cases, requires one hour of continuous nursing care and observation. By the time the patient is ready to be transferred to the postpartum floor the doctor has usually completed her chart and this is sent down with her.

It should be emphasized that, regardless of how well prepared or how adequate the obstetrical nursing staff may be, it will be able to function only to the extent that the medical staff practices the principles of good obstetrics and lends itself to suggestions that will enable the nursing personnel to adhere to the highest quality of obstetrical nursing standards.

Play Therapy for Special Needs

ETHEL KAWIN

THE article, "Play Therapy—a New Science," which appeared in the April 1939 issue of The MODERN HOSPITAL, discussed play programs for hospitalized children with particular reference to age, level of development and individual needs. This article will deal with toys and play activities for two groups of children with special needs.

Let us consider first children with cardiac impairment—unfortunately a common ailment. A long-time, careful plan for the child's play program is obviously needed if the disorder is of a congenital type. Even for children whose heart trouble is not of congenital origin, wise provision for constructive use of the child's time is important because periods of acute illness and convalescence are likely to be protracted.

Boys and girls whose normal activities are thus curtailed are entitled to be kept as contented and happy as possible. Furthermore, in cases of heart impairment, exercise within prescribed limits and a program of gradually increased activity are usually important aspects of the care and treatment ordered by the physician.

Various physicians, occupational therapists, play therapists and others who have particular interest in children suffering from cardiac diseases have from time to time formulated lists of play materials and activities suitable for certain groups.* The following is such a guide.

1. Patients with organic heart disease and with symptoms of heart failure when at rest, who are unable to carry on any physical activity without discomfort. These are extremely ill children who must remain in bed and are allowed a minimum of activity. They may usually have quiet entertainment but no actual handwork. This is likely to limit their entertainment to listening to stories and music and to looking at picture books and scrap books.

2. Patients with organic heart disease, unable to carry on ordinary physical activity without discomfort. These are patients who are still in bed and whose activity must be greatly limited. They may do handwork but with a minimum amount of exertion. They may handle large light toys, string large beads, use pegboards of different varieties and dress paper dolls. Usually children in this stage can carry on a variety of projects with colored paper, *i.e.* folding, tearing, cutting, weaving and pasting it; they may make chains, weave mats and fold objects of paper. Playing with simple picture puzzles of light construction is often enjoyed.

3. Patients similar to group 2 but whose activity is only slightly limited. These patients are likely still to be in bed but are able to sit up. They may do arm work which requires some pressure and some skill, such as making scrapbooks, weaving, playing with pegboards and using construction materials of cardboard, light wood or erection sets. Colored mosaic blocks, picture puzzles and books to color are other possibilities. Simple sewing and basket-making may be enjoyed for brief periods. Blueprint outfits with which the child can create his own pictures may be the source of much delight.

The type and amount of activity that may be permitted the child with a heart impairment should be decided by the physician who has the young patient under his care. He should be the one to decide whether passive or active exercise is advisable and the duration of any such activities. The restrictions imposed are likely to vary from time to time, depending upon the child's condition.

Children who suffer from organic heart disease but are able to be up and about may be permitted a limited amount of activity, including building with small blocks and construction sets.

Pictures by courtesy of Marshall Field & Company, Chicago.

Miss Kawin is director of guidance, Glencoe Public Schools, Glencoe, Ill.

*These groupings are usually based upon the functional classifications of patients with heart disease adopted by the American Heart Association. A playthings guide based on chronological age will be found in The MODERN HOSPITAL of April 1939, p. 46, or in Chapter X of "The Wise Choice of Toys," by Ethel Kawin, University of Chicago Press. Lists given here were prepared by the Chicago Heart Association and the author for an exhibit of toys for children with cardiac impairment arranged by Marshall Field & Company and the University of Chicago.

With improvement in the patient's condition, the physician usually can permit a greater variety of activities and then selection may go beyond the suggestions included under group 3. The child who is able to be out of bed but who is not permitted to move about may play with a doll-house, cut paper dolls and paper furniture, use crayons and paints, write on blackboards and build with small blocks and a variety of light construction sets. For a patient in this stage there are mild throwing games, such as quoits and ring-toss, which the child may play if someone else does the walking. Wide areas of new interests for such shut-in boys and girls may be opened up by maps and by varieties of board games and card games. Object, animal, bird or flower lotto games will help to bring them the out-of-doors of which they are deprived.

The list of available play materials and activities can be further extended when the child is able to walk about, even though the amount of his physical activity must be limited. Discretion must be used, of course, in the selections made, and competitive or highly exciting activities should be avoided.

Crippled children constitute a second group with special needs. They are particularly important, not so much because of their absolute numbers but because of their long hospital stay. The child crippled from accident or from infantile paralysis must be given individual study because his play opportunities will depend upon his individual condition. The limitations imposed by casts, braces and the appliances of a fracture bed differ widely.

One type of crippled child, however, merits special discussion. This is the "spastic child," who suffers from cerebral palsy. These children may present almost any combination of physical and mental capacities from the mildest symptoms to extreme physical or mental handicaps. For such children special programs of training are imperative.

The treatment of cerebral palsy, aside from surgical operation, consists of a series of physical exercises designed to relax and develop the muscles and to bring them under voluntary control. A muscle may be relaxed and exercised by inducing movements of the child's limbs while the child himself remains passive. Voluntary control of motor movements cannot, however, be established by induced motions; such control, by its very nature, is dependent upon the cooperation of the child.

A young child cannot be expected to go through the drudgery of routine exercises; he cannot understand the value of muscle training in terms of future activity. The child's cooperation can best be gained through the medium of play activities. Children who may rebel against prescribed exercises will gladly obtain manual exercise by rolling and pressing clay "cookies," by playing tag or through singing games, such as "Here We Go Round the Mulberry Bush," especially if phonograph records accompany his play.

Any program of exercise for the "spastic child" should, however, be planned and carried out only under the supervision of the physician who has a thorough knowledge of his patient's condition, because emotional disturbances are likely to be caused by an attempt to force the child beyond his physical capacity.

Toys That Encourage Hand and Arm Movements

Peg boards	Construction sets
Picture puzzles	Archery sets
Nests of cubes	Dolls to dress
Screw boats	Paper dolls
Weaving sets	Trains
Noah's arks	Boats
Farm sets	Automobiles
Village sets	Bean bags
Blocks	Lock-blocks
Small pool table	Cut-outs
Bingo Bed	Accordion
Krazy Ikes	Balls

Everything possible should be done to keep these children comfortably happy and interested. Insofar as possible they should be relieved of all emotional strain and fear; every effort should be directed toward giving them feelings of relaxation and security. Their educational and social adjustments should be considered just as carefully as the improvement of their physical accomplishments. All children have need of the satisfaction and stimulation of successful performance but children with spastic problems need such encouragement as a constant stimulus. They should be exposed as little as possible to experiences of frustration and failure.

The play activities of these boys and girls must usually take place under supervision because they are likely to need help in manipulating materials. For them guidance in play activities is important because even carefully chosen toys and games will not in themselves teach them what they need to learn. Children with a hand or arm disability, for example, are clever in devising ways of playing so that they use the "good" hand or arm instead of exercising the muscles that need the special training.

For the most part, toys used by children in general are desirable for those with spastic paralysis because the ordinary toy is likely to call for the use of both hands and, therefore, to provide the training in coordination that these children especially need. Toys that will interest the child and stimulate him to effort and continued activity should always be within his reach. His efforts must bring him satisfaction and a sense of accomplishment; otherwise, he is likely either to demand entertainment provided by others or to slump passively into the inactivity of resignation.

All thought of competition should be kept away from the play of this group of children. The child himself may reach a point, however, where he can derive encouragement from his own record of progressive achievement. His efforts, no matter how crude, should never be laughed at but, if a sense of humor can be constructively developed in such a child, it will be a great asset to him throughout life.

A rich field of finger-play may be explored for exercising hand and arm muscles. The fingers may become birds sitting on a fence or little pigs "going places." There are the old games, such as "Peas Porridge Hot" or "Handpile," that can be played by two or three children. When the lights are on in the evening, making shadow pictures on the wall may provide a fascinating exercise for hands.

The materials that call for finger-play also offer great variety. Stringing beads may be adjusted to the amount of finger dexterity the child has, as beads range in size from very large to very small. If the metal

There are all kinds of toys designed to restore muscular coordination without the drudgery of routine exercises. Play exercises that help the children to develop leg and feet muscles include walking boards and jungle gyms which are particularly suitable if there is an open-air play space available.

tip that is found on strings made for this purpose is too short for the child to handle, a longer wire may be substituted. Modeling clay, plasticine or wax has unlimited possibilities. If these materials are too stiff for a particular child to manipulate, heavily floured dough, which is softer and responds to touch very easily, may be used instead. Drawing, either at tables or with easels, is another process that offers a beneficial field of activity for many children with impaired hand or arm movements. Large crayons should be used, and the paper should be fastened with thumbtacks.

Water play, loved by all children, is especially attractive to boys and girls with spastic difficulties because the buoyancy provided by the water helps the quality and success of their performance. Pushing floating toys, such as ducks and boats, in a broad, low pail of water brings pleasant feelings of power to these children for whom a feeling of power is hard to gain. A sand box with all sorts of toys to accompany it—a shovel, pail, strainer, sand villages or similar equipment—brings to the child happy hours and beneficial exercise.

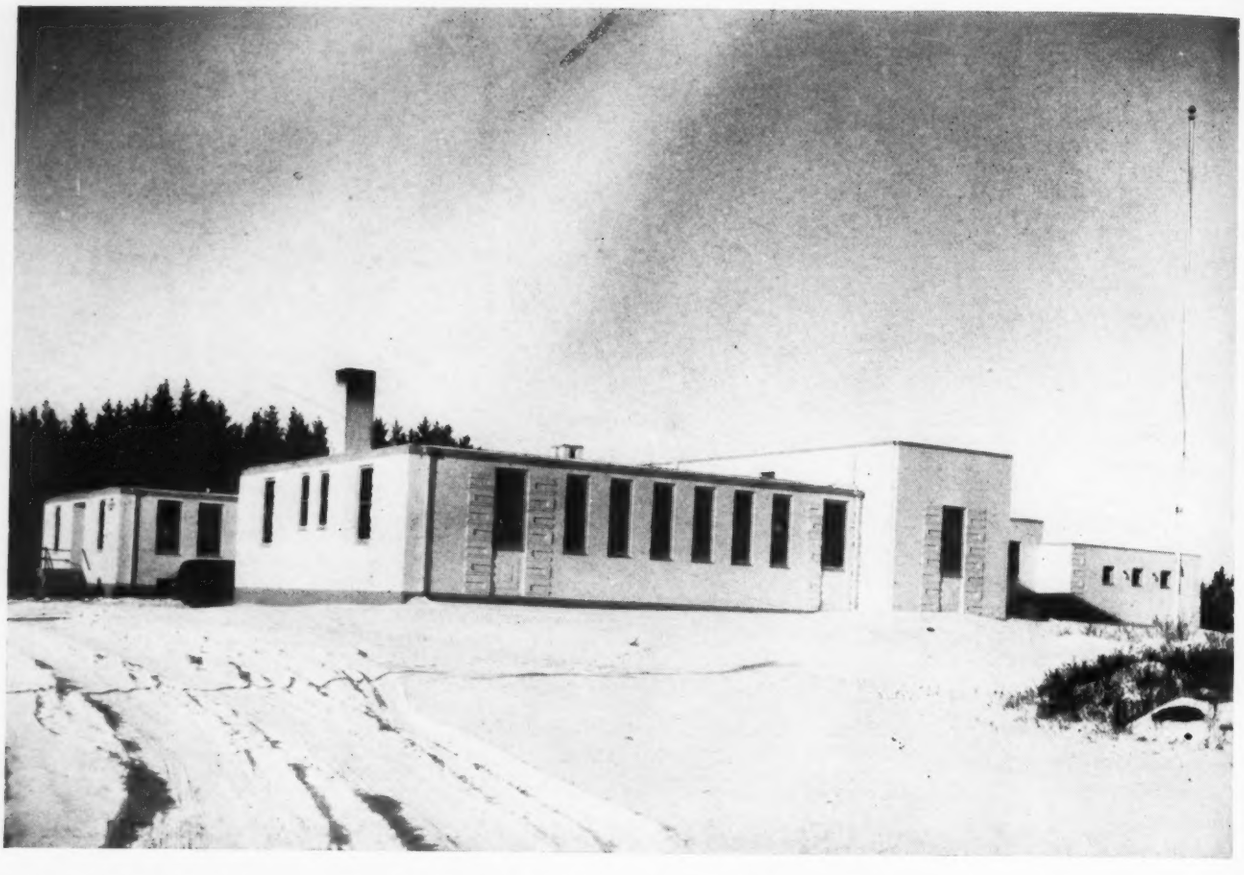
While "wind-up" mechanical toys are not usually desirable for children because the activity is too much in the toy rather than in the child himself, they are worth while for children who especially need muscle training and for whom the action of the toy furnishes incentive for finger exercises.

Play exercises for helping children to walk and to exercise legs and feet in various ways are of great value for children who need special incentive or special assistance in developing these functions. Kiddie-cars, tricycles, jungle gyms, walking-boards and little ladders may be selected according to the age and needs of the individual child. Many of these are not suitable, of course, for hospital situations, but they may be used if there is an open-air play space available. One new type of velocipede has a flexible frame. Push-and-pull toys, wagons, wheel-barrows, pedal automobiles and similar toys involving locomotion offer attractive opportunities for activities to meet the special needs of many of these children.

The lives of these boys and girls may be greatly enriched by some of the arts and crafts. It is important that in choosing the art or craft, thoughtful attention be given to the capacities and limitations of the child for whom the selection is made. Simple types of carpentry may gradually grow into greater complexity; painting offers valuable exercise and almost unlimited possibilities; scrapbooks of all kinds engage the child's interest and can be made with satisfaction, even if his coordination of movement is not precise. If possible, some art or craft should be chosen in which the child can really excel.

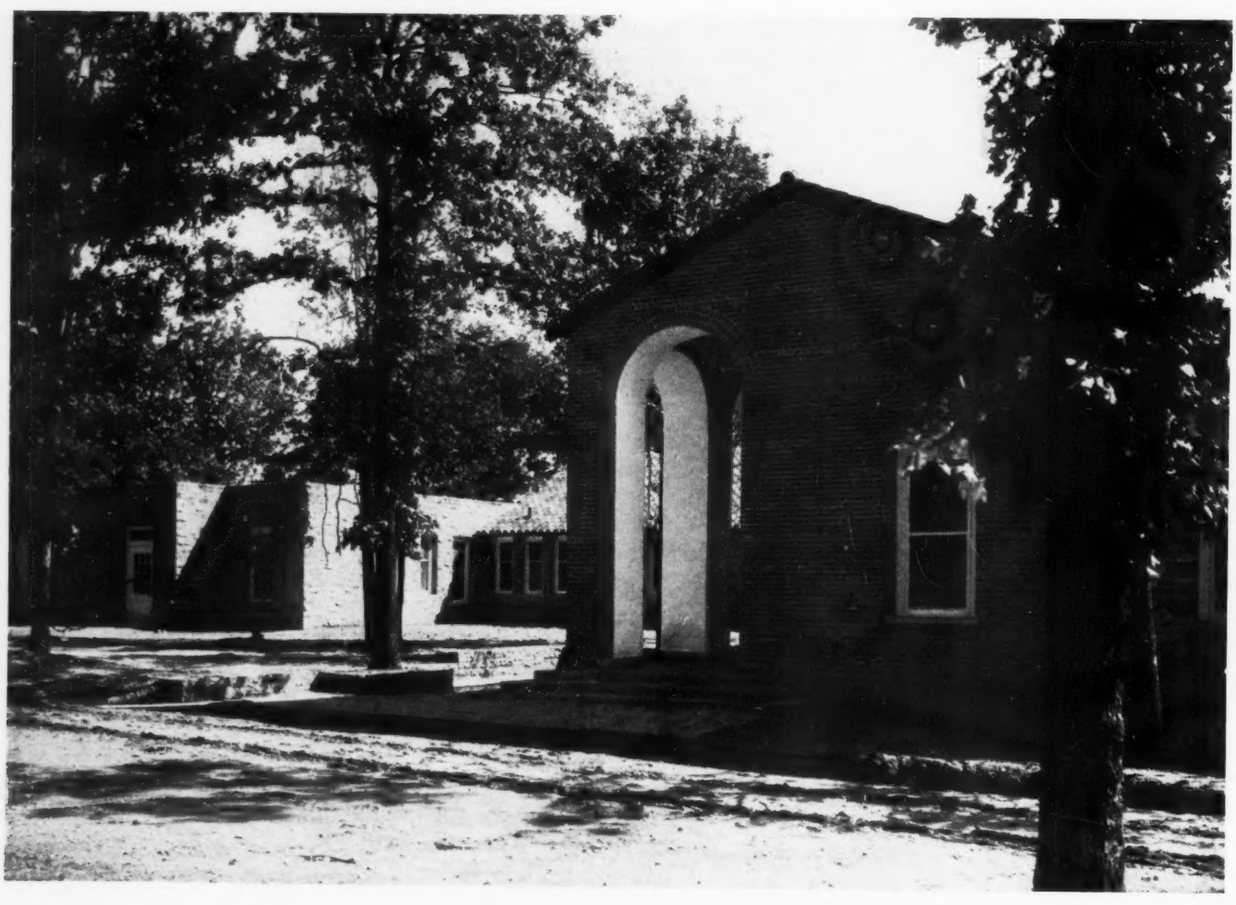
Children suffering from spastic difficulties may profit greatly from varieties of board and card games. Football and baseball, learned through table-board games, will help such a child understand and share the activities and interests common to children in general.

Thus, through carefully planned play programs, the confining walls of the hospital may be pushed back. The special needs of every such child are physical, psychological and social. The hospital should do all it can to meet these varied needs so that the child may function as normally as possible, both while he is a patient and when he leaves the hospital.



Above: Indian designs were used to decorate the Consolidated Chippewa Agency Hospital, which is set on a pine covered knoll up north in Cass Lake, Minn.

Below: In sharp contrast to the winter scene above is this photograph of the main entrance and east wing of the 69 bed Hastings Hospital at Talequah, Okla.



Hospitals on the Reservations

CARL A. ERIKSON

MUCH remains to be done to bring the long neglected Indian hospitals up to physical standards worthy of a service operated by the United States of America for its wards, the Indians.

Most of the hospitals that have recently been constructed have replaced frame structures totally unsuited for care of the sick; others have been built in areas that formerly had no hospital facilities whatever. Even yet, many of the Indian service hospitals are not up to acceptable standards. There are still some that are without x-ray facilities, laboratories, operating rooms or delivery room. A number of them are so packed that they can be compared only to the six patient beds of the Hôtel Dieu of Paris in the Middle Ages. In these Indian hospitals each patient has a bed but they are so close together that to reach the patient the nurse must push the beds around to form virtually one very wide bed. And then there is the 250 bed hospital housed in several two story frame buildings that were built as schools about fifty years ago.

The personnel and services that are belatedly being furnished the Indians are not a bit of altruism of the Great White Father's. Quite the contrary. They are generally a tardy fulfillment of treaty obligations in which the government agreed, in return for substantial compensation, to furnish, among other things, complete medical care for the Indians.

Because of this obligation the Indian hospital differs markedly from almost all other hospitals, governmental or otherwise. The physical well-being of every Indian from the cradle to the grave is the concern of the health officer in charge of one of these hospitals. He is on call for visits to the Indian's shack, no matter how remote or difficult of access. One of the doctors in the service has a territory about 150 by 100 miles with only one passable road in it. Another one has an area in which he drives his automobile as far as he can and travels the rest of the way on the horse that he has carried on a trailer.

In many agencies no doctor travels without complete equipment for digging himself out of the mud or for spending the night on the road in the bitter cold or blizzard. It's some job! But the physician must be a great deal more than physically capable of being able to take it. He must be health officer, surgeon, physician, obstetrician, nurse, pharmacist, roentgenologist, pathologist and all the specialists rolled into one. He is the apotheosis of the general practitioner. He must be, when, as happens too often, he is the only doctor in an area bigger than the state of Vermont.

To demonstrate his versatility the doctor, in theory, is also the administrator of the hospital. Fortunately, however, this part of his job has been reduced somewhat since all but local purchases are made through the Washington office.

Nurses Are Versatile, Too

The nurse in the smaller Indian hospital must be no less versatile. Nursing is her primary job but she must be a teacher as well. She trains patients to assist her, for without such assistance she could never get her work done. She is the anesthetist, housekeeper, information clerk, record clerk and pharmacist, as well as dietitian and surgical and obstetrical supervisor. When the doctor is away she must assume the responsibility for the care of emergency cases that come in. No doubt there are also times when she must do the cooking.

Truly a versatile crew and one that requires a streamlined work shop.

The medical officer in charge cannot be choosey in the patients he admits. He must take them all if he has room or can make it (which is not the same thing). A childbirth case often is complicated by active tuberculosis and sometimes by venereal disease. A contagious disease patient must be cared for somehow. In most hospitals provision must be made for isolating the tuberculous. Housing from 20 to 50 sick people of this kind in a single hospital presents problems in nursing and medical technics that are made doubly difficult by the limited personnel available. It was, therefore, thought best to plan the Indian hospitals of less than 50 beds as though they were virtually contagious disease units. Hence, every room and ward are provided with a private or connecting toilet. To lend flexibility in space assignment, no rooms have more than four beds. While there are no private rooms, it is planned to use available two bed wards as quiet rooms when necessary. Most of the hospitals have a section for tuberculosis. All of them have at least two rooms that can be used to care for the more virulent contagious diseases, with toilet and shower and the usual door to the hospital corridor. The windows in these rooms are triple hung so that the corridor doors may be sealed and the patients placed in complete isolation with service from the outside.

Patients stay longer in the Indian hospitals than is the case in other hospitals because, unless they complete their convalescence in the hospital, they are likely to return for an extended stay. Then, too, many chronic disease patients must be cared for, housing conditions among the Indians being what they are.

Of course, the object is to keep the Indian out of the hospital. The field nurse is one line of attack, home calls by the doctor, another and the third is the out-patient department. While an attempt is made to channel out-patient service into regular "office hours" it seldom succeeds. This complicates the problem since the out-patient and in-patient staff is identical in these tiny units. It is obvious, too, that equipment cannot be duplicated; one instrument sterilizer, for example, must necessarily do the job for all classes of patients. The x-ray department and the laboratory must be equally convenient for the in-patient and out-patient services, which, in turn, must be near the doc-

Mr. Erikson is a member of the architectural firm of Schmidt, Garden and Erikson, Chicago.

tor's office and examining room. Formulary dispensing of pills and castor oil is done by either the doctor or the nurses.

Visiting is just as difficult to control in these places as in the larger ones, probably more so, because there are not so many people to do it.

Careful analysis of these and many other elements that enter into the planning of the Indian hospitals indicates that the hub of activity is the nurses' station. It was, therefore, decided to place it so that the nurse would be able to: supervise the in-patients; supervise and direct the out-patients; be ready to assist the doctor; control visitors; operate the sterilizers; have all needful medical supplies within reach, and dispense drugs.

This is done in all of this group of hospitals by expanding the otherwise small nurses' workroom into a good working unit and by placing the nurses' station in it. The nurse's desk overlooks the reception room used by both out-patients and visitors. An electric door lock, controlled from the desk, admits one either to the hospital corridor or to the examining area. Since the workroom also adjoins the doctor's office or examining room, sterilized instruments, supplies or assistance can be provided for the doctor from the same central point. The nurses' workroom is always next to the single operating room so that apparatus can be sterilized and bandages prepared there.

The business office, as such, is lacking in all of these hospitals of less than 50 beds because the chief medical officer is the administrator. Records are kept in the workroom.

In one other respect this group differs markedly from the usual hospital. None of these hospitals under 50 beds has more than one operating room and none has a birth room. This is direct reflection of the staffs' limitations. Most of the hospitals of 30 beds and under are one-doctor hospitals; those of from 30 to 50 beds are two-doctor hospitals. The staff is supplemented whenever possible by a consulting staff from the vicinity. Unfortunately, many of these have no other doctors close by, and in some areas not all of the doctors are qualified to cooperate.

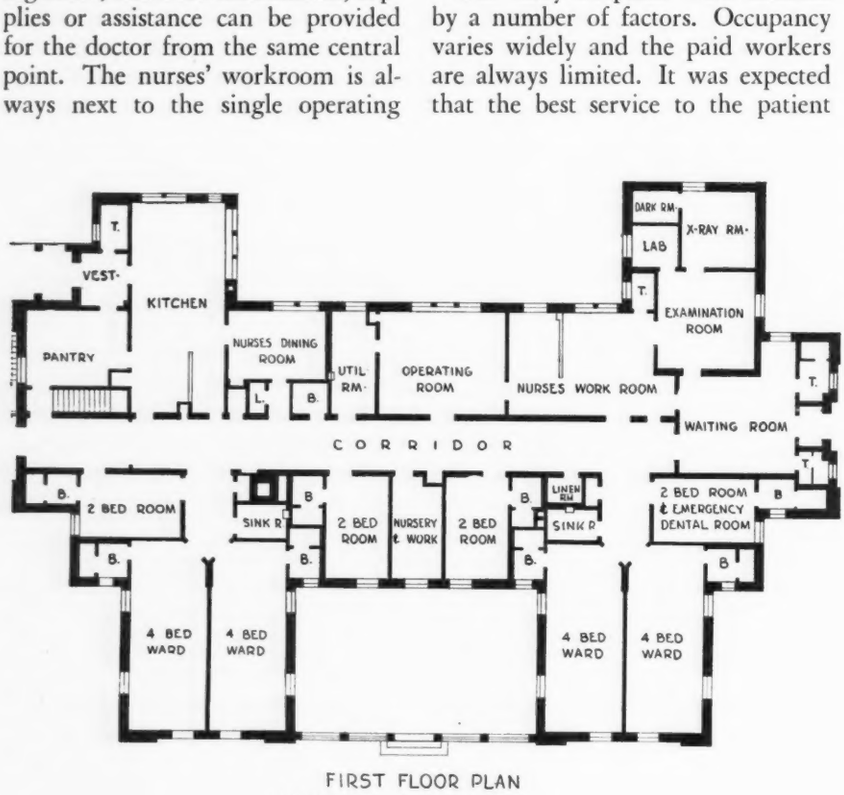
For these reasons it was obvious that only a single operating room could be utilized to advantage.

In all but two hospitals the kitchen is on the patients' floor. This permits the nursing staff to supervise the kitchen more readily and eliminates the necessity for serving pantries and lift equipment.

One story hospitals were dictated by a number of factors. Occupancy varies widely and the paid workers are always limited. It was expected that the best service to the patient would be obtained at the lowest expenditure of personnel energy by grouping all patients on one floor. As the nurses' station must be the center around which the hospital is operated, the out-patient department, visitors' room, operating and other medical services must likewise be placed on the same floor with the patients. Furthermore, the one story plan effected economies in construction. Few stairs and no lift equipment are needed; auxiliary rooms of all kinds are reduced to a minimum, and there need be no duplication.

Basements are developed under about half the area of each building; the rest is excavated only enough to accommodate a 4 foot pipe space. Storerooms large enough to carry the half yearly or yearly shipment of supplies occupy a large part of the basements. The usual morgue is found in each one.

The heating plant is also in the basement. Fuel is either stoker fired coal or oil. Boilers are high pressure (to provide sterilizer steam) and each one is sized to carry 75 per cent of the estimated peak load. Thus, either boiler will probably carry the load from 90 to 95 per cent of the time, leaving the other one in reserve. To avoid the waste of fuel, so evident in our overheated hospitals, hot water (forced circulation) is the actual heating medium. Thermostats located in the patients' quarters act in conjunction with one at the hot water heater to change the water temperatures and thus avoid overheating or underheating. Radiation is of the convector type. This, like the plumbing and electrical installation, was kept as simple as possible to come within the repair abilities of local mechanics. In the waste lands where many of these hospitals are located, there is no possibility of telephoning for instantaneous service.

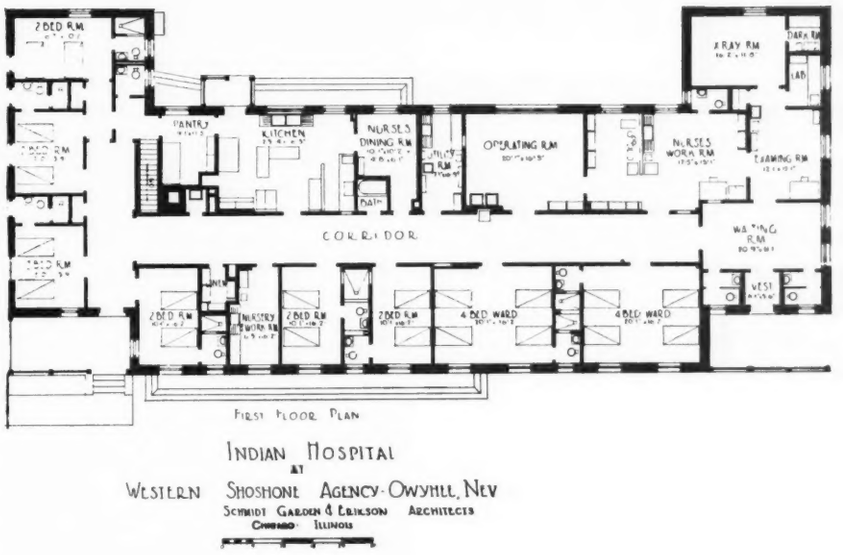


FIRST FLOOR PLAN
UINTAH AND OURAY
SCALE IN FEET

The exterior of the Uintah and Ouray Agency at Fort Duchesne, Utah, is built chiefly of reddish stone. Two 4 bed wards located at the left of the entrance are for tuberculosis cases. The nurses' workroom adjoins the operating room, the examining room and the waiting room. Twenty-four patients can be accommodated.

For this reason, too, an effort was made to use local materials as much as possible, though a basic requirement was that the hospitals were to be of fire-resistant construction. As carried out, that meant masonry exterior walls, *i.e.* stone, brick or reenforced concrete, depending on the local materials. When trucking costs 4½ cents per pound and an oil tank has to be cut in two because it cannot be snaked around the sharp bends in the road, "foreign" materials become extremely expensive.

All floors are reenforced concrete, supported on concrete joists or bar joists or light weight "I" beams. Partitions are either hollow tile or gypsum; in one or two cases where haulage was excessive, they were constructed of solid plaster on wire lath. Flat roofed buildings have roofs of the same construction as the floor with a suspended plaster ceiling below. The buildings that have pitched roofs have a wire lath and plaster ceiling carried on light weight steel supports at the ceiling, with a wood joist roof on steel purlins. Pitched roof materials are generally covered with a light weight clay shingle tile. The nurses' and doctors' quarters are masonry walled with wood joists and wood stud partitions, both protected by plaster on wire lath.



The Western Shoshone Agency Hospital at Owyhee, Nev., has a capacity of only 20 beds. The 2 bed room at the upper left is for isolation cases. Right: The basement plan, which is typical of all the hospitals, shows the location of storerooms, boiler room and laundry.

Because the Indian hospitals are humble and poorly furnished, it was suggested that the standards of interior finish generally accepted for other hospitals might be lowered and considerable saving effected. Fire-resistant construction could not be abandoned but might it not be practical to omit all plastering and leave the floors of cement? This idea was abandoned, however, when the relatively small savings in initial costs were balanced against such considerations as increased cleaning and maintenance costs, the need for aseptic conditions and the realization that the Indians would be quick to sense the inferior quality. Therefore, while every detail was closely examined as to its value and cost, the resulting finish is one that differs little from the better hospitals everywhere. Floors are generally of terrazzo, with a 5 inch cove base. Door frames are of steel. Walls are of plaster, with Keene and Portland cement wainscoting where necessary. No tile or marble is used. The rooms are illuminated by a switched overhead light and by night lights, which are also found in the corridors. Window sills are of steel; the windows, of wood with double hung sliding sash. The nurses' call system is of the usual type.

The rooms themselves are painted in low toned colors. In some of them two walls and the ceiling are of one color with the other two walls of another color; in others, three walls are alike with a white fourth wall and a blue ceiling. The doors, door trim, radiators and window sash are then usually picked out in a strong color, *i.e.* blue, burgundy, red, green, yellow or brown. Sometimes these doors are in three tones, one for the trim, a lighter one for the stiles and rails and a still lighter one for the panel. Corridor colors change either vertically or horizontally. The sharp accents, the varied wall and ceiling colors and the effect of sunlight and shadow, controlled by venetian blinds and artificial light, make an interesting and constantly changing effect, both in the individual rooms and in the entire unit. Since one color costs about the same as another, the cost was negligible.

The hospitals illustrated in this article are but a few of the nearly 100 hospitals and sanatoriums totaling about 4000 beds operated by the U. S. Office of Indian Affairs to care for the 320,000 Indians (220,000 wards of the government) who, contrary to popular belief, are not a dying race but are estimated to be about as numerous now as they were in 1100 A.D.*

*The enthusiastic cooperation of the Office of Indian Affairs in meeting the many problems involved in determining the size, location, planning and construction of these hospitals is gratefully acknowledged. Difficulties were ironed out through the thorough knowledge of the Indian Service of John A. Collier, commissioner; William F. Zimmerman, assistant commissioner; James G. Townsend, medical director; Edward A. Poynton, director of construction; Eleanor Gregg, director of nursing, and Samuel S. Dodd, then chief finance officer.

Your Employes' Health

HOSPITALS, being centers for health, should set an example to the community in the quality and extent of health service provided their employes.

Small hospitals, however, sometimes believe that a satisfactory health program for employes is impossible to achieve. The superintendent of a hospital recently apologized for the fact that nothing whatever was done to discover disease in her employes by stating that the employes all came from the local community and their family doctors constituted the medical staff of the hospital. Granted that this is true, isn't it putting an unfair burden upon the doctor to expect him to report employes who have or may have hidden sickness?

The following statements by small hospitals in various parts of the country indicate that it is not only possible but profitable to make good health provision for employes.

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NEARLY all of our employes and medical staff enrolled recently in the Northern Illinois Hospital Service Corporation, Rockford, Ill. These employes will hereafter be paid their salaries during illness and their hospital bills will be paid by the hospital corporation.

We have not yet started giving health examinations to employes. Whenever one of them has a cold we take him off duty and try to hospitalize him if possible. We find that employes recover much faster when they are hospitalized than when they remain at home.—HILDA WHITEFOOT, *Woodstock Hospital, Woodstock, Ill.* (45 *beds*).

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ALL applicants, including those for the nurses' training school, are given a thorough physical examination before the applications are placed in the approved files. This includes chest examination, urinalysis, blood chemistry, including Wassermann test, and a report from the dentist that the mouth and teeth are in good condition. The candidate is charged for the dental examination only. I find that this method is truly a case of an ounce of prevention's being worth a pound of cure. In a number of instances we have found conditions that would have caused considerable difficulty, particularly in cases of employes who work in close contact with others. I might add also that a routine Wassermann test is made twice a year or more often, if necessary, on employes who are classed as food handlers.

We are more than glad to take care of any of our student nurses who become ill while on duty free of charge, although the time spent off duty because of illness must be made up at the end of the training period. When employes outside the training school become ill, if they have given faithful service for some time, we care for them as long as is necessary. Usually we do not take them off the pay roll for three weeks; if they are ill longer than that they are given half-salary up to six weeks. Although the salary stops then the necessary care continues.

The program outlined may seem elaborate for a small hospital, but most of our personnel, both in the kitchen and in the rest of the hospital, has been on the staff for ten years or more, with an average of only one or two days' sick leave each. —REGINA H. KAPLAN, *Leo N. Levi Memorial Hospital, Hot Springs, Ark.* (75 *beds*).

• •

OF COURSE, applicants for the nurses' training school have a physical examination. We also require that all of our kitchen employes be given an examination which includes a Wassermann reaction, but not x-ray or tuberculosis examinations; we do not make Schick and Dick tests on employes. Ordinarily, only the one examination is made unless there is some condition that requires checking later.

If employes are enrolled in a hospitalization plan, we give them two weeks' hospitalization without loss of salary; if they do not have this insurance, we give them hospital care but they are taken off the pay roll during their illness.

We have a "safety" program under the supervision of each department head, which has done much to cut down the rate of minor accidents—W. A. SALLEE, *secretary, Fitkin Memorial Hospital, Neptune, N. J.*

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ALL of our employes are given a thorough physical examination, including blood tests, at the time of employment. They are also examined at least once a year during the period of their employment. Particular attention is paid to blood and chest conditions. Free medical and hospital care is given but all sick leave is at the individual's expense.—AGNES HEMAN, *Christian Hospital, St. Louis* (90 *beds*).

• •

WE BELIEVE that hospitals should have definite health plans for their employes because the principal functions of the hospital are to prevent and to cure disease. Good health, like charity, should begin at home. Furthermore, it is the first duty of a hospital employe to realize the importance of sanitation.

When an application is made in person for a position in the Sanitarium of Paris, the following questions must be answered on the application blank: "How much time have you lost because of illness during the last three years? What was the nature of the illness? What is the name of your attending physician?" If the application is considered favorably, the information given is checked and a health certificate is requested. (Usually, if there has been a history of illness, one of our staff members has been the attending physician.)

Applications for entrance to the training school must be accompanied

by a form executed by an examining physician of the applicant's choice. When approved, this is filed, and a checkup is made at the end of three months. Thereafter, annual examinations are made and the results are recorded for reference.

The superintendent of nurses is responsible for the execution of the health program. She directs the educational program and arranges for the services of a physician when they are required. After an applicant is accepted, he is instructed as to the duties of his new position and, at the same time, the importance of his health in relation to his job is emphasized. Upon the request of a department head, the superintendent of nurses will advise any employe concerning his particular health problem.

Employes are advised to report all minor complaints to their department heads. The department head, in turn, reports these to the superintendent of nurses, who accompanies the employe to the examining physician, if necessary. The chief of the medical staff directs the health service and the other staff members accept the responsibility for examining employes referred to them by the chief medical officer.

Service is available to employes at all times and every facility of the hospital is open to them. Examinations include routine laboratory, and Wassermann reaction, x-ray, Schick and Dick tests, when clinical signs indicate the necessity for them. Employes who come in contact with patients are immunized against typhoid fever and smallpox. Nurses, kitchen employes, housekeepers and linen room workers are isolated when they have colds. Compensation insurance is carried for protection in case of accidents.

Sick leave and provision for hospitalization have long been a part of our health program. Every employe is granted sick leave with pay for two weeks out of a year. In case he remains in his home during his illness, we send his dinner to him. We have never limited the length of hospital stay. All employes are now enrolled in the group hospital service plan.—MARGARET E. KENNEDY, *Sanitarium of Paris, Paris, Tex. (72 beds).*

Tips From Two Hospitals

Basement Dining Rooms

• If your dining room is in the basement, you will be interested in a chat, by proxy, with Esther Wenger, superintendent of the 30 bed Highland Hospital, Belvidere, Ill.

Highland Hospital is well named, being on the highest point of land in the immediate neighborhood. But

Highland Hospital at Belvedere, where painted hollyhocks grow.

the dining room was put in the basement to be near the kitchen. It was given a light well but, in spite of this, a black floor, dark walls and the streaked concrete of the light well walls made it the opposite of cheerful.

Miss Wenger couldn't afford to replace the floor or to re-cover it, but she could and did paint lighter colored strips around the edge to give somewhat the effect of a large carpet. Then she transformed the walls with golden tan paint and with large panels of scenic wall paper.

The final touch was the painting of the inside of the light well, facing the dining room. The wife of a patient who had been in the hospital for many months is an artist. During her husband's illness, she spent much time in the institution and became well acquainted with the entire hospital family. When she heard of the dining room beautification project, she offered professional aid. Now the nurses and employes look out their dining room windows on to a painted border of hollyhocks against a garden wall. The dismal basement room has become a cheerful dining room overlooking the garden. So attractive is it that the county medical society now holds its monthly meetings there.

Keeping Nurses Contented

• The secret of keeping good graduate nurses in small hospitals, according to Clara Ellen Boeck of Condell Memorial Hospital, Libertyville, Ill., is to provide them with good equipment, employ only well-trained and high-class nurses, have reasonable working hours and give good food and good pay.

Condell Memorial has a daily average census of 17 patients, who are cared for by six nurses. Two other nurses can be called in when the patient load is high.

This well-appointed and fully equipped hospital is about 30 miles from Chicago. The nurses like to go into Chicago occasionally so the time schedule is arranged to make that possible. In each four weeks' period, each nurse has two half days off, one full day off and one week end (from Saturday noon to Monday morning). Nurses receive $80 for day duty and

Winter landscape at Condell Memorial Hospital, Libertyville.

$85 for night duty with full maintenance. They work eight hours on most days with 8½ hour shifts occasionally when the schedule is being shifted.

Two of the nurses are trained to do laboratory and x-ray procedures and thus are able to fill in when the part-time laboratory and x-ray technician is not available.

Congratulations, Miss A

● CONGRATULATIONS on being a Woman in White. Those crisp immaculate uniforms symbolize the sanitation and efficiency of the hospital to every patient, visitor or salesman who crosses the threshold. You outshine any man superintendent when it comes to a garb that is appropriate to the job in hand.

● IT MAKES SENSE to us, Miss A, your system of paying the nurses enough salary so that they can live like normal young women outside the ivy-covered walls of an institution. It's praiseworthy, too, that you don't concern yourself overmuch with their off-duty engagements beyond making newcomers feel at home and providing recreational facilities.

● ALL HONOR to you again, Lady, for maintaining your own apartment outside the hospital where you can flop on your chaise longue to read the Small Hospital Forum or where you can brazenly entertain friends at dinner in your hostess pajamas. That blond cocker of yours has all the alertness and honest friendliness of his mistress. As for your jalopy, it's one step up from the Joads' conveyance and, on the inside looking out, the scenery is often beautiful. So we are told by that assorted collection of townsfolk who enjoy bouncing about the countryside with you.

● WE LIKE the Mother Confessor side of you, too. How other women superintendents and prospective fathers and doctors with home problems and troubled high school girls flock to you for advice! One of your colleagues told us that she was ready to resign her hospital job the day the board voted to exclude her from its future meetings. But, after talking to you, she agreed to discuss the matter individually with each one of her trustees and now she's back at board meetings enjoying new respect.

● CONGRATULATIONS, too, on educating your board to the need for its superintendent's attending professional association meetings. And when you arrived at the national convention in the next state flanked by Farmer Beanblossom and Banker Cashew all set for the trustees' section, we were ready to proclaim you a super super.

So Sorry, Miss A

● WELL, REALLY, Miss A, when we walked into the front door of your hospital the assault on our olfactory organs was an affront. We know that some obsolete buildings have been none too successful in eliminating odors but the "hospital smell" can be eradicated if there is the will to do it. Put that good mind of yours to work on the problem.

● SURELY YOU can find a spare sunporch or some isolated area for circumcision ceremonies. The relatives at one recent event chattered so loudly and long over their wine and cake that the maternity patient in the adjoining room had a setback and was an extra three days in the hospital.

● YOU CERTAINLY CREATED a town scandal in the way your nurses handled the Scott case. How would you feel, Miss A, if you came to visit your supposedly convalescent baby only to find the room empty and the little body removed to the morgue! When the floor nurse noticed an abrupt change in the baby's condition, she should have seen that the parents were notified immediately.

● WHY NOT PAINT the inside of the public telephone booth there in the front lobby some ravishing color! That dirty white plaster surface you have is an invitation to doodlers, and they have accepted the challenge. You can put up a shelf in the booth and make some scratch pads out of discarded mimeographed sheets or outmoded letterheads so that patrons can write down telephone numbers and messages without inscribing them for posterity on the plaster. It's too, too untidy the way it is now.

● RESTAURANTS have been known to grow rich or to go bankrupt over the coffee they serve patrons. If your hospital had to stand or fall on the strength and flavor of its coffee, there would be a mighty crash! Heavens, what swill you serve! Of course, some patients don't protest because they think their taster is at fault, what with illness playing tricks on them. But others know your coffee for exactly what it is and, if there were another hospital in town, they'd patronize it come next illness. Change your brand, change your recipe, change your container, but, whatever the cost or inconvenience, build a reputation on excellent coffee, the good-will ambassador.

Before an Operation—

Is an Internist Consulted?

MARTIN G. VORHAUS, M.D.

IT HAS been routine procedure in some of our better hospitals for the surgeon to invite the cooperation of the internist in preparing certain patients for operation. Unfortunately, the rôle of the internist too often has been limited by a request that only an opinion as to the operative risk in a given case is required. At times just an expression as to the type of anesthesia to be administered is asked.

Where Internist Can Help

There are a variety of disease conditions that offer opportunities for the internist to demonstrate his value in the medical-surgical partnership. Of these, the chronically ill patient is an outstanding illustration.

There are numerous examples of this type of patient in every hospital, including cases of chronic empyema or lung abscess in the chest group and cachectic gastro-intestinal malignancy and chronic inflammation, such as regional ileitis or ileocolitis with or without fistulae, in the abdominal group.

Too often the surgical service summarizes the preoperative preparation as "a transfusion and glucose intravenously." Such a therapeutic plan takes cognizance of the high spots only. Here is work for the medical man. One large transfusion may be embarrassing to the overburdened circulation, whereas repeated small transfusions are more effective and just as economical.

Similarly, how often can an underfunctioning liver and pancreas adequately aid in metabolizing a glucose intravenous injection? In such cases additions of thiamin chloride and ascorbic acid may be extremely effective. Both of these vitamins are important in the oxidation reduction system of the body. Both have significant relationship to the oxidation of sugar and to glycogen synthesis and storage in the liver.

Doctor Vorhaus is an associate attending physician at the Hospital for Joint Diseases, New York.

At this point the internist may ask for a week or more to prepare the patient. Twenty mgms. of thiamin and 100 mgms. of ascorbic acid daily will bring a depleted patient up to saturation or close to it within a week.

About fifty grams of glucose daily can then be adequately handled, broken down and stored as glycogen that will be available for the postoperative exigencies. Three hundred cc. of blood can be safely administered and the daily blood counts during the preoperative week will indicate whether there is need for a second or third additional small transfusion.

In surgical procedures necessitated by such long continued infections as abscesses, the need for preoperative medical care is especially great. The ability of the patient to create immune bodies is intimately tied up with liver function, as well as with the activity of the less specialized body cells. More blood and more sugar are, of course, desirable but the entire vitamin requirement of the cell is also needed to effect an adequate immunobiologic response.

To these patients high caloric and high vitamin foods are essentials in the preoperative management, but too often there is a great discrepancy between theory and practice. The surgeon orders a "high vitamin, high caloric diet"; the dietitian works it out and prepares it; the nurse brings it to the patient, but does the patient eat and can he assimilate the food that he needs?

This, too, is a problem for the internist. Often, multiple vitamin supplements are necessary to bridge the gap between the theoretical vitamin content of the diet offered to the patient and the actual amount of vitamins that reach the body cells.

A tired, pus-ridden patient may represent simply an iron deficiency, an anemia that a "high vitamin, high caloric diet" often fails to correct. It is the responsibility of the medical man to assure an additional and, at times, a surprisingly large amount of iron in that important preoperative period.

The association of a hyperchromic anemia with carcinoma occurs often enough to justify taking the time necessary for the internist to administer liver extract parenterally and to watch the reticulocytic response as the index of the type of treatment that will be needed.

Atrophic changes in the gastrointestinal tracts are recognized when the medical man is able to point out the coexistent and telltale atrophic glossitis, but even with an apparently normal tongue these changes may be sufficiently marked in the stomach and small intestines to alter the normal digestion and assimilation that are so important to good health. Here again time is needed to administer the vitamin complex (B and G, usually) that promotes mucous membrane regeneration. Subclinical states of sprue and pellagra are frequently found to be concomitants of surgical states.

Reducing Thyroid Mortality

In the surgery of the toxic hyperthyroid patient all the conditions that favor the development of vitamin lack are operative and concomitantly present. The persistently elevated basal metabolic rate significantly increases the need for vitamins B and C. The tachycardia favors the development of a myocardium subsaturated with vitamins and glucose. The frequent achylia gastrica in hyperthyroidism further complicates the nutritional derangement. Muscular overactivity and toxemia favor the onset of peripheral neuritis. The liver undergoes its well-known focal necrosis which, with a disturbed physiology of liver function, may lead to lessened glucose and vitamin storage in this organ. It has been proved that only the closest type of

cooperation between the physician and surgeon will bring down and keep down thyroid mortality.

It is not only to the general surgeon however that the internist may offer constructive aid. Gynecology and obstetrics present many problems that require closer cooperation between specialists in these fields and their medical confreres. The literature of the past few years is replete with proof of the greater need of the pregnant woman, as well as the unborn child, for minerals and vitamins.

The anemia resulting from pelvic malignancy or from bleeding fibroids calls for careful medical management that should be given before operation, if possible. The frequent association of pyosalpinx with achylia is usually overlooked by the gynecologist but its effect on the nutrition of the patient is often marked.

The internist should be permitted to show his worth to the orthopedic surgeon also. The prolonged application of plaster in the numerous immobilizations needed in orthopedic conditions makes the patient prone to the development of peripheral neuritis. Adequate dietary control and the continued administration of thiamin are of great preventive, as well as curative, value. The corrective surgical measures in poliomyelitis, chronic arthritis and osseous tuberculosis are too often performed on weak, undernourished and anemic subjects. The same measures already outlined can be instituted in the orthopedic wards with as much value as in the surgical wards.

Let's Be Proud of This Hospital

HELEN CODY BAKER

LET'S talk about something pleasant. Let's be proud of Chicago. In spite of the relief situation, we have several good reasons. I saw one of them last week.

It's a hospital. You wouldn't know, at first glance, that it is the most remarkable hospital in this city, and one of the most remarkable in the United States. There's the same sharp, clean smell that meets you as you cross any hospital threshold; the same spotless coats on the interns (perhaps just a bit whiter than some you have seen), and the same crisp, blue uniforms on the student nurses. There nothing unique, either, about white enamel, glass and chromium equipment.

The hospital is affiliated with the medical school of the University of Chicago, but other hospitals are affiliated with leading medical schools. Why, then, is this the most remarkable hospital in Chicago?

Let's begin with the little things and go on to the bigger ones. I think the faces of the doctors, nurses and patients here are the most cheerful I have seen in any hospital. The hard-driven look I have come to recognize in such places and the look of suffering that is so familiar in hospital wards weren't characteristic of these faces. Every man, woman and child I saw (and I saw it all, from the classrooms on the seventh floor to the dynamos humming in the basement) looked glad to be working there or content to be cared for.

Another little thing: This hospital is beautiful. The floors are a soft gray tile. The walls are soft green tile, or pale rose pink, or delicate buff. The auditorium where clinic patients await their turn is one of the most cheerful rooms I have ever seen used for this purpose.

Fifteen more little things: very little. Tiny hands, tiny faces, tiny dark heads. Fifteen brand-new babies, and not a blond among them. Not a white baby in this hospital. Not a white nurse. One white patient, who looked glad to be there. When I heard what was being done for him I understood it very well. He's a lucky man. Any sick person is lucky to be a patient in Provident Hospital.

It has been called the finest Negro controlled hospital in the world. It is the only hospital in the United States that offers postgraduate training to Negro physicians. It is the only training school for Negro nurses in the state of Illinois.

"But surely that *can't* be true," I exclaimed, thinking of Cook County Hospital . . . thinking of the taxes that citizens of every race, creed and color pay to support it . . . thinking of the heartbreaking need for Negro nurses . . . thinking that nursing is a service profession and that even men and women with more prejudice than vision must recognize that here, of all places, the color line should be wiped out. But it is true.

"What about a Negro hospital, for Negroes, staffed by Negroes?" I asked Dr. John Lawlah, the medical director and superintendent. "Isn't it a step toward segregation, and is that where we Yankees really want to go?" His answer sounded like an axiom, but it had the ring of truth proved by hard experience:

"A man can only attain his full stature when he is in control of the situation where he works. We have a staff of 88 highly efficient men. Less than a third of them could practice medicine in any other Chicago hospital."

One more difference: Provident Hospital needs support more desperately than any other voluntary hospital in this city. That's a strong statement, but the figures stand behind it. Including the 165 beds in Provident Hospital, only one fortieth of the 10,116 beds in our voluntary hospitals are available to Negroes. Yet Negroes number one twelfth of our population.

Generous gifts from the Rosenwald Fund have helped, for the last few years, to meet a steadily mounting deficit, for Provident charges less than the cost of care. The Rosenwald Fund money is almost gone, but the need increases each year. In 1938 there were 23,000 more clinic visits than in 1937.

A final reason. And now I am talking to white folk. There are few of us whose lives are not touched, directly or indirectly, by those of our Negro neighbors. The health of this huge population is vitally and selfishly important to us. Sickness can't be segregated.

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Impetigo Loses Another Round

M. L. BUSCH, M.D.

IN ORDER to prevent the outbreaks of impetigo that had recurred from time to time in the nursery of the Edgewater Hospital of Chicago, we built a new nursery equipped with certain facilities which the staff felt would eliminate cross-infection. This nursery has been in use for more than a year and up to the present date we have had no cases of impetigo or any other infection among the new-born.

Our nursery is now divided into six rooms: the main nursery for normal babies, a formula preparation room, a room for premature babies, an isolation department, doctors' examination room and a locker room.

The main nursery is equipped with two ultraviolet air sterilizers and an air conditioning system. The latter filters the air and controls the humidity. The temperature is kept at 78° F. and the humidity, between 45 and 50 per cent. Ultraviolet lamps at each end of the room are directed toward the ceiling. The walls of this room are pale blue and the woodwork, windows and doors are finished in ivory.

Doctor Busch is superintendent of Edgewater Hospital, Chicago.

A cubicle system for each infant was devised by members of our staff. Each of the 24 cubicles is supported by a metal stand and is enclosed on three sides by shatterproof glass. The front is open to allow the nurse to take care of the infant. Beneath each cubicle is a drawer containing all the supplies needed for that infant during its stay in the hospital. These include diapers, sterile supplies, dressings, applicators, oil, thermometer, cord dressings and other items used in the care of infants. By having individual supplies for each baby, cross-infection is reduced to a minimum.

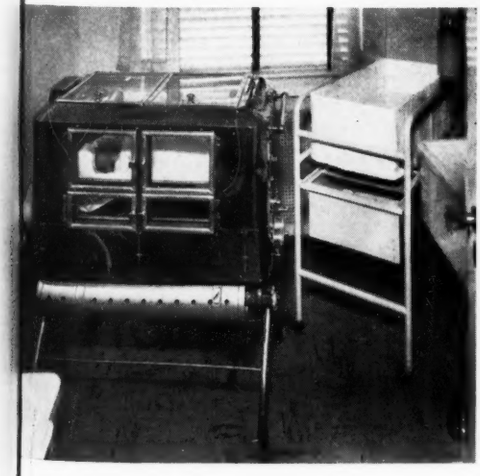
The formula room is located in the northeast corner adjacent to the main nursery. It contains a large autoclave for sterilizing bottles and milk, and a water sterilizer that is equipped with a filter and a cooling device so that all the milk and food can be kept at the proper temperature. Nipples are also autoclaved.

The premature department is in the south wing of the nursery. This division has three compartments each containing an incubator. In addition, there is an incubator with special features devised by one of the staff members, which is operated under complete thermostatic control. The infant can be observed, dressed, changed and fed without being removed from the chamber at any time, and thus is not exposed to sudden changes of the room temperature. Oxygen can be administered into this incubator in any percentage and the effect can be observed through a glass cover. Temperature, humidity, oxygen and carbon dioxide are automatically controlled.

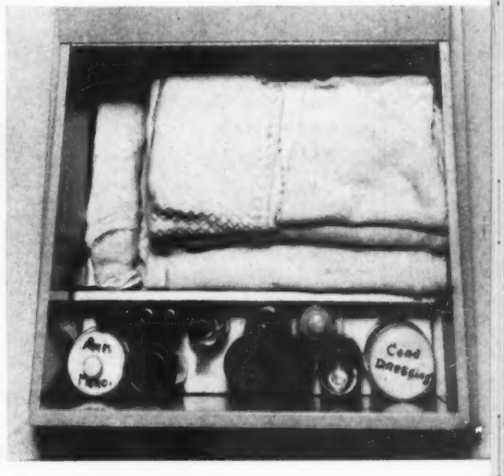
The isolation room is in the southwest portion of the nursery and has a cubicle system similar to the one in the main nursery. The entrance to the isolation room is entirely separate from the main nursery. However, the partition between the two is made of glass so that the nurses can always see the isolated infants while they are in the main nursery.

Certain cases may require the use of oxygen. To avoid carrying in

Special incubator designed by a staff member. The infant can be observed, changed and fed without being removed from the unit.



Left: A corner of the formula room. Below: Each cubicle is equipped with a drawer that contains all the necessary supplies.



tanks, a separate oxygen supply compartment was installed in a chamber adjacent to the doctors' locker room. The tanks are kept in this compartment and the oxygen is carried through concealed pipes to outlets in the main nursery, the isolation room and the premature department.

The two ultraviolet air sterilizers in the main nursery were installed in order to decrease the number of organisms in the air. The efficacy of this equipment was confirmed by bacterial counts made of the various nursery rooms as compared with those made of the outside corridor.

Another feature that has a great deal to do with the success of the present system of impetigo control is technic.

Individual baby blankets are provided for the mother and are kept in a paper bag at the bedside. A white tab indicates the top of the blanket. By means of this tab the blanket is always kept in the same position and the infant always lies in the same spot in the blanket.

Whenever the infant is brought in for a breast feeding, the mother is instructed to expose her breast and to turn on her side; the blanket is then opened lengthwise with the tab at the top. The breast is sprayed with 4 per cent boric acid solution and 70 per cent alcohol is sprayed on the hands. The open blanket is placed on the bed and the mother's hands rest upon it until the infant is put to breast. The mother is instructed to avoid touching the child during the nursing period.

A general view of the individual bassinets enclosed on three sides by shatterproof glass. The nursery is air conditioned and equipped with two ultraviolet ray air sterilizers.

During supplementary feedings the infants are held and fed individually. The nurses stay with them throughout this feeding to watch for any possible aspiration of food contents.

The glass cubicles and the drawers containing the supplies are cleansed daily by the nurses after the 10 a.m. feeding period. An attendant, wearing a cap, mask and gown, mops the nursery division twice daily using an antiseptic solution. No one except the nurses on duty or the attendant who cleans the rooms is permitted in the nursery division.

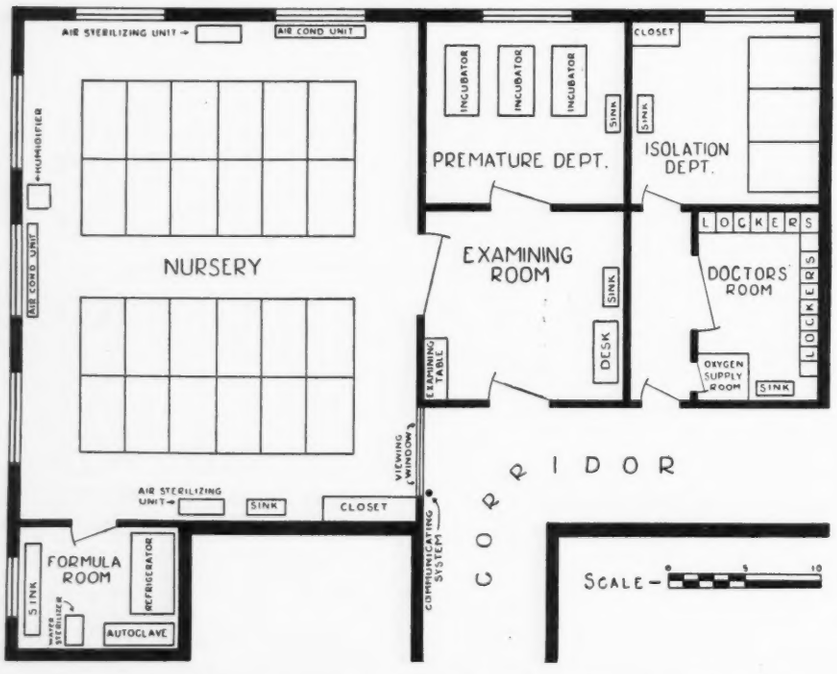
Circumcisions are performed on the eighth day upon full-term babies that are in good condition. When performed by a doctor, they are carried out in the delivery room and the usual aseptic precautions are observed.

A special room is provided for ritual circumcisions. A mohel performs the operation in the presence of the father with the usual aseptic precautions employed by the doctors. The spectators concerned with the ritual are on the outside looking through a closed glass door. After a circumcision the bed is tagged to call attention to the nature of the operation and the infant is given special attention and observation. Vaseline dressings are applied after each voiding until healing has occurred.

On the ninth day the mother is given instructions in the care of the new-born. This is done with the mother in the corridor separated from the demonstrating nurse and baby by a glass wall. Mother and nurse are able to converse freely by a loud-speaker system.

Before discharge from the nursery, the baby is examined by the attending physician and then signed out. When the mother is ready to leave, the baby is checked by an assistant nurse, who inspects the tag and identification marks.

Physicians are permitted to make examinations on infants only in the special room provided for this purpose. They must wear a gown and mask and must cleanse their hands before they are permitted to touch the infants.



Plan of the nursery department. The formula room adjacent to the main nursery contains an autoclave for sterilizing milk and bottles.

Latin America Steps Forward

A significant step in the advancement of hospital service in Central and South American countries was taken when the first Latin American Hospital Congress met in January

OFFICIAL delegates from 13 South American and Central American countries participated in the first Latin American Hospital Congress which met in Santiago de Chile. It was decided that similar congresses should be held every three years and the next meeting is scheduled for Colombia in 1943.

The countries officially represented included Argentina, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Guatemala, Panama, Paraguay, Peru, Uruguay and Venezuela.

Papers were presented on hospital organization, administration, equipment and construction; feeding; social insurance; maternal and child care; care of contagious diseases; integration of medical care; accounting; psychiatry; physical therapy; social service, and the preservation of human milk. The social program arranged for the delegates included tours of several new hospitals in and around Santiago.

Nineteen Resolutions Adopted

The important resolutions adopted by the congress include the following:

1. It is strongly recommended that the Latin American governments organize hospital associations in their respective countries.

2. Warm interest is expressed in the periodical organization of similar congresses on dates and in places that may be chosen.

3. An exchange of hospital administrative personnel must be established as a permanent institution among the Latin American countries as an important factor toward progress and solidarity.

4. A Latin American hospital directory, as well as hospital administration and science reviews, should be published for the benefit of the hospitals.

5. Every hospital must constitute not only a center for diagnosis and treatment but also a center for prevention and education. All hospitals must cooperate with the various institutions that contribute to the protection of human life, and their first duty is to become identified with the general policies of social aid and public health of which hospitals are one of the essential factors.

6. To fulfill such objectives, it is essential that hospitals should possess complete equipment and be adequately financed.

7. The hospitals of a country should be organized into hospital zones with adequate coordination of effort among institutions.

8. Patients should be treated promptly to avoid unnecessary delay and a costly stay in the hospital.

9. Because the management of a hospital is highly technical, the administrator should be a doctor who possesses special knowledge of hospital administration and social medicine.

10. Permanent courses for the training and advancement of hospital administrators should be organized in the Latin American countries.

11. Vertical construction (a concentrated building) is recommended for hospitals.

12. The same vertical construction is recommended as ideal for psychiatric, tuberculosis, contagious and convalescent hospitals, provided there is ample independence in services. Under special circumstances, the pavilion system may be accepted.

13. The vertical system of construction is recommended even for small hospitals, if it is properly adapted to the needs of each region.

14. All general institutions, especially children's hospitals, should have a pavilion for the isolation of contagious disease cases.

15. It is recommended that specialized contagious disease hospitals be erected in every important Latin American city, in accordance with the morbidity rates of the particular city.

16. Since hospitals for lepers do not offer any danger to the healthy population, the congress adopts and reiterates the conclusion of the International Leprosy Conference of Cairo in respect to the locations of such hospitals near cities.

17. It is recommended that each Latin American government erect psychiatric hospitals for acute disease cases at least in every capital city. These hospitals should be provided with all necessary pavilions and should be organized on the plan presented by Professor Arturo Vivado.

18. Dietetics should be taught in schools of medicine and nursing and to auxiliary medical personnel.

19. Food service departments that are adequately staffed and equipped should be created. They should be under the supervision of physicians who have specialized in the field of dietetics.

New Buildings Are Inspected

Among the new hospitals visited by the delegates were the Sanatorium-Hospital for broncho-pulmonary patients in Santiago, the Anti-Tubercular Sanatorium at Valparaiso, the Viña del Mar Hospital at Viña del Mar and the regional hospital at Valdivia. Dr. Gustavo Fricke, director of the Viña del Mar Hospital, will be remembered by many members of the American Hospital Association who had the pleasure of meeting him at the Toronto convention.

The president of the Latin American Hospital Congress is Dr. Javier Castro Oliveira, general director of public welfare, Santiago, Chile.

Minneapolis General Seeks a Foolproof Tuberculosis Technic

J. A. MYERS, M.D., F. E. HARRINGTON, M.D., and T. L. STREUKENS

SUCH inroads have been made by tuberculosis on the personnel of hospitals and sanatoriums in the past that one of our first considerations in establishing a tuberculosis service at Minneapolis General Hospital was the adequate protection of those who come in contact with patients.

During the year July 1938 to July 1939, we kept a record of each student nurse who served in this department in order to determine the efficacy of our technic in preventing an initial tuberculosis infection. Each student who had not had a tuberculin reaction previously was tested at the beginning of her service. We tried to obtain a retest on each one six weeks after the completion of the service, which is six weeks long. It was not possible to complete every record, however, because the students come from eight or nine hospitals, some of which are out of the state.

The following figures summarize our findings during the first year: 92 students were reactors to tuberculin at the beginning of service; 109 were nonreactors at the beginning of service; 79 were nonreactors six weeks after service; 10 were reactors six weeks after service, and 20 were not available for a retest.

Two of the students who reacted to tuberculin during this period had contact with open tuberculosis cases immediate following their service on the communicable disease ward. In two others, three months or longer elapsed before the retest was made. The remaining six were probably infected during their service with the tuberculous patients, although their subsequent services in the medical wards, the dispensary and other parts of the hospital may also have supplied sources of infection.

It has been suggested that the tuberculous patient can be educated to protect the members of the hospital personnel. However, on most tuberculosis services, particularly in our tax-supported sanatoriums and general hospitals, some patients are mentally subnormal; some cannot even comprehend the cause of their disease and how it is transmitted to others, and some who have a clear understanding of the disease and are most cooperative become so ill that they are fighting desperately for breath and cannot possibly give consideration to the contagiousness of their disease.

There is also the incorrigible patient and the one who maliciously spreads his tubercle bacilli. While we are cognizant of the fact that this type of tuberculous patient is rare, at the same time such persons must be taken into consideration.

Protecting Student Nurses

Again, it has been said that the student nurse knows she is dealing with tuberculosis and, therefore, can protect herself against this disease. This is impossible unless we provide her with the necessary equipment, encourage her to use it and teach her every necessary step in carrying out contagious disease technic. The student nurse is young and her experience is so limited that she cannot possibly have the perspective that includes an appreciation of the remote hazards of infection with tubercle bacilli.

On a six weeks' detail in the contagious disease building, nurses are rotated through all of the contagious disease services, including two weeks of tuberculosis nursing, with relief for other communicable diseases, and four weeks during which contact with tuberculosis may occur through relief service.

There is a definite distinction between a student's exposure to a disease and her experience in the nursing care of a disease. Throughout the entire six weeks spent on contagious diseases, the students are exposed to tuberculosis from time to time. For example, one student nurse relieves another on the tuberculosis floor during a meal hour. The night "floater" makes rounds on each of the floors, caring for the critically ill on any floor and, thus, the student nurse is brought in contact with tuberculous patients frequently over the period of her six weeks' service in contagious diseases.

In every large class of student nurses there is at least one who is indifferent and careless and who will not obey all the rules laid down by the hospital. If such students are not detected and eliminated before they enter a contagious disease service, there is considerable danger of their becoming infected because of failure to practice adequate technic. Again, there is the possibility of an occasional accidental break in technic. Moreover, we may expect approximately 1 per cent per year to become infected from sources outside the hospital.

When this service was established at Minneapolis no one expected that the technic first employed to protect personnel would be perfect. The tubercle bacillus differs from the diphtheria bacillus and the typhoid bacillus with reference to its longevity after it leaves the body. There-

The section dealing with the protection of student nurses was prepared by Ida McDonald, R.N., who has developed and applied the contagious disease technic on this service in a most efficient manner. The authors are associated with the Minneapolis General Hospital, the Lymanhurst Health Center and the departments of medicine and preventive medicine of the University of Minnesota. The paper was prepared with the aid of a grant from the research fund of the University of Minnesota.

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fore, it was understood that perhaps some special procedure would have to be developed to make the technic adequate for preventing the spread of tuberculosis. One of the procedures now under consideration is a cellophane device to cover the entire head, face and neck. This will eliminate the use of the ordinary mask and will completely protect those parts of the body from tubercle bacilli. Another protective device is a cloth boot, which is easily put on and removed and can readily be sterilized to reduce contact with contaminated floors and halls.

The result of the first year of observation on students has been most gratifying. Only 10 in 89 have been found to react to the test following this service and in four of these there is considerable doubt whether the infection was contracted on the service. The percentage of those who became tuberculin reactors on our service, including four who may have become infected after leaving it, is only 11.2. Boynton found on a similar service in another institution that 22.2 per cent were infected. Our goal is to develop a technic that will protect the student and other members of the personnel so that the infection attack rate on this service will exceed that in the general population only slightly or not at all.

Prior to the establishment of this service, the Minneapolis General Hospital had a bad reputation among students and graduates of medicine and nursing because of the frequency with which contagious diseases, including tuberculosis, were transmitted to members of the personnel. This would be true of any hospital under similar circumstances. It was known to all that an obstetrical, diabetic or surgical patient might also be suffering from contagious tuberculosis. No section of the hospital was known to be free from patients with the disease in a contagious stage. Moreover, one member of the personnel did not know how many other fellow members were spreading infection.

The establishment of a special tuberculosis service and adequate examination of all entering patients, as well as of all members of the personnel, immediately dispelled the fear. Moreover, the personnel realized that every possible effort was made to protect it against tuberculosis while on this service.

The question has been raised as to the attitude of tuberculous patients toward the practice of contagious disease technic. We have had little difficulty with new patients who really desire to control their disease and to protect their families; in fact, they are eager to learn the methods so that they can apply them subsequently in their homes and elsewhere. Persons who have objected to or criticized the technic have been the occasional patients who had had previous care for the same disease in hospitals where the technic was not used.

This service has been extremely helpful to the schools of nursing that are affiliated with the Minneapolis General Hospital. For example, one of these hospitals has a tuberculosis service composed largely of advanced cases for chest surgery. The supervisor of nurses will allow no student nurse on this floor until she has completed the work on the tuberculosis service at the Minneapolis General.

It seems highly important to us that this service continue without interruption. Every general hospital has the same basic problems of tuberculosis. Patients may have coexisting disease and mistaken diagnoses. Adequate technic to handle these problems is imperative if for no other reason than that tuberculosis has already been adjudged an occupational hazard in some states. Moreover, further work must be done to define contaminated articles so that restrictions may be applied at the essential points and reduced at nonessential points.

The cost of operating the tuberculosis service is low because all of the medical work is of a routine nature. For example, the laboratory examinations are those that are being done regularly in any good general hospital, and this also applies to the x-ray work. The cost of the actual care given the tuberculous patients is less per day than the cost in the county sanatorium because in the general hospital the services of the physicians are donated, whereas in the county sanatorium all staff members are paid.

You've Got Me Wrong, Dr. Clay

BUT I was glad to see your article on "Another View of Intern Service" in the February issue of The Modern Hospital. The "filler" published in the November 1939 issue under the title "Who Sells Intern Service?" was intended to be provocative, to show the other side of the picture and to offset the frequent statement by staff doctors that the hospital is selling medical service through its interns.

Where do you get the idea that I do not advocate contact between the intern staff and private patients just because I bring up samples in rebuttal? Not only do I approve, but I insist that interns be in constant attendance whenever the attending doctor's orders permit them to be. It is one of the most important phases of their instruction, particularly in a teaching type of hospital. The interns here are the first assistants in at least three quarters of the operations. We wish it to be so, but this does not alter the fact that such assistance is a contribution of professional services by the hospital —a contribution to the patient or the doctor as the case may be.

Similarly, the interns do practically all other diagnostic and treatment procedures under the attending doctor's instructions, which again is as it should be, yet these are chargeable medical services if they are performed by a practicing physician.

It would be inconceivable to me not to have interns on the private service to assist with history taking, routine rounds and the emergency that may arise.

This is where you've got me wrong, Doctor Clay.—George S. Stephens, M.D., *Winnipeg General Hospital, Winnipeg, Man.*

What We Need Is Teamwork

RAYMOND P. SLOAN

Frankness is the keynote of this discussion of the need for cooperation both between trustee and administrator and among individual board members who should work as a team

"WHAT'S going to happen to our voluntary hospitals? Will the government step in and take them over? Where can they look for support?"

These are questions we hear frequently these days. The answers rest with the trustee. The future of the voluntary hospital lies in his hands. What is he doing to build up a solid line of defense against potential government interference, if it may be regarded as such? What is he doing to prove the importance of the voluntary hospital in public health affairs? Is he accepting the challenge of a changing social order by readiusting his services to conform with broader health policies, at the same time coordinating them with existing health agencies? Does his hospital speak as one voice with no discordant note to mar the effect of complete unity and accord?

Without complete unity and accord, without unselfish devotion to serving mankind, without confidence that what we stand for is right, there is little hope of winning any cause. On the other hand, we had only to read the foreign news this winter to thrill over what could be accomplished against the greatest odds with everyone working unselfishly together as one team in grim determination to fight against the ruthless invasion of personal rights and privileges.

What the voluntary hospital needs today in solving its many problems is good teamwork—closer coordination between policy-making and administration. This holds for professional interests, too, although the latter deserves discussion by itself. We can hope to win only by achieving an alliance that functions smoothly and with the utmost precision.

A successful team works together, each member knowing precisely the part he is to play and how he can best supplement the efforts of others. Personal glory or gratification is subjugated to the advancement of the team as a whole. And we assume, of course, a captain who has the ability to direct, a capacity for leadership, one who is able to gain and to maintain the support and respect of each individual.

How many hospitals today can boast of such teamwork? Not enough, judging from close observation. A curious conflict is discerned on the part of some board members in their attitude toward hospital affairs. With apparently the best intentions they are being destructive rather than constructive. Quite unconsciously, they are projecting themselves, their ideas and beliefs into the foreground at a sacrifice of hospital progress, and not always with the full approval of their fellow trustees. Not content with confining themselves to their own vital rôles of policy-makers or governors, they are encroaching even upon administration.

This attitude may be exemplified in one individual, or two, possibly even more. It has even been known to be carried to the point where it has disrupted the entire organization, bringing disrepute to an otherwise outstanding institution.

Trustees frequently raise their voices in protest at government intrusion. If politics is permitted to enter the hospital, all is lost.

But what about their own politics? Before worrying about what the government is going to do to the voluntary hospitals, should the trustee not stop to consider what he may be doing to them, unknowingly, of course?

What factions are seeking control for personal or other reasons? Who dictates the policies of church and fraternal institutions and do these policies always conform with best hospital practice? Is it the determination to serve public health needs as they actually exist or as they are interpreted?

Public spirited men and women are daily making generous contributions of time and money to voluntary hospitals. Without them where would the country's hospitals be today? All the more unfortunate, therefore, when such outstanding service is marred by a seeming inability to practice good teamwork.

Good teamwork demands complete accord not only among those individuals comprising the governing board but between the governing board and the administrator. No longer is the operation of the hospital turned over to those who are unqualified professionally to assume such responsibility. Hospital administration has finally won recognition as a profession, with university courses and refresher course, or "institutes," available to establish and maintain higher standards.

Assuming that the administrator speaks with authority, his voice should be heard and heeded. He should enjoy the complete confidence and respect of everyone. It seems hard to believe that there was a time when some trustees or boards of governors met behind closed doors without the presence of the hospital executive. Yet surprise is expressed at the revelations disclosed when surveys are made of individual institutions as well as of community health services. Certainly, blame for the inefficiencies uncovered cannot be attributed wholly to management if

From a talk delivered before the New England Hospital Association, Boston, March 9.

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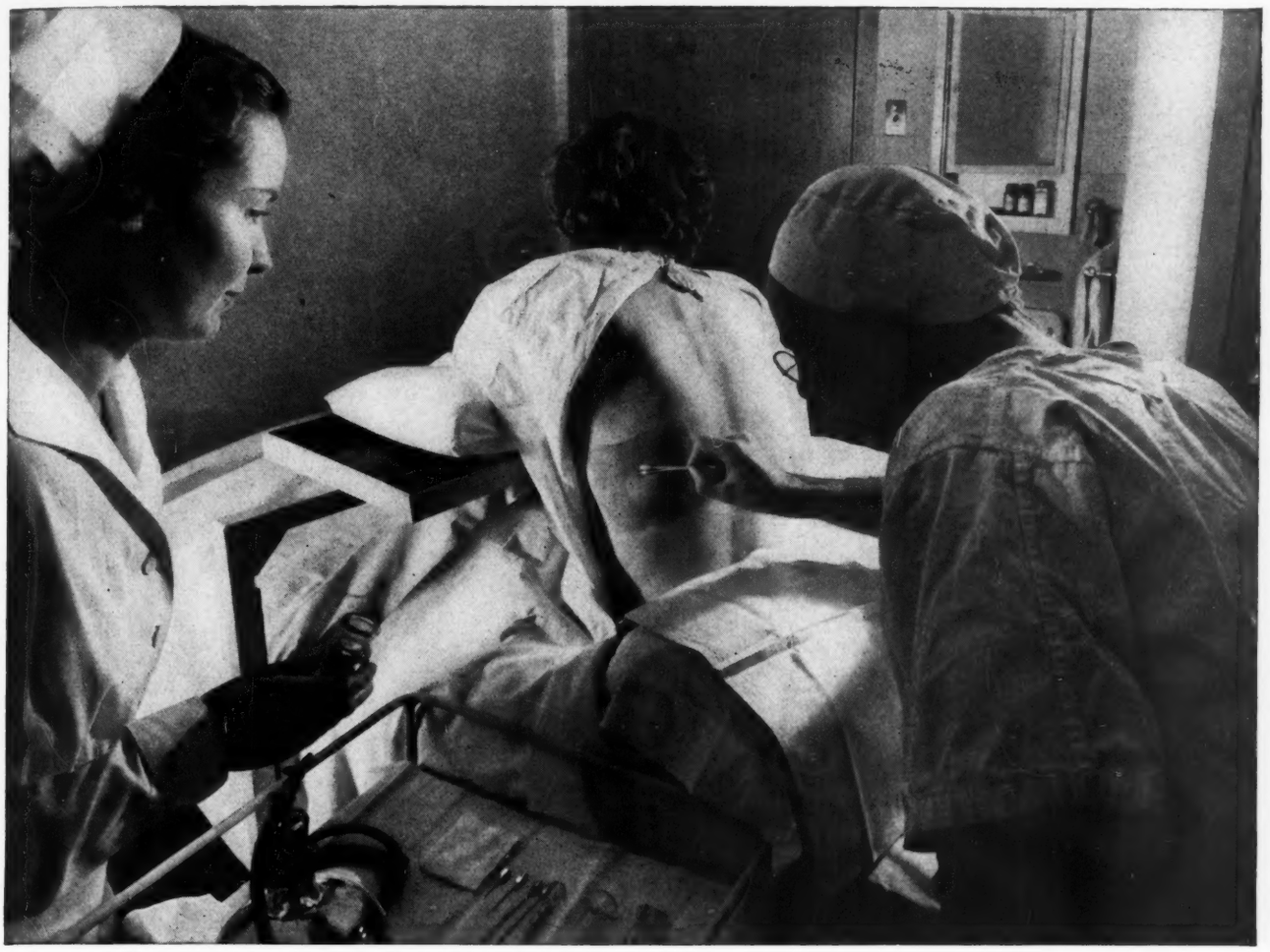

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that management fails to enjoy the confidence of its directorship.

Few of us would feel justified in bursting in upon a busy executive at any hour of the day, or after business hours even, without calling first to find out whether it would be convenient or signifying in some way that we would like a meeting. Nor would we feel abused if, on calling without some notification, we were advised that he was busy or out of the office and that we would have to wait or call some other time. Yet there are trustees who have been known to stand indignant at the door of the superintendent's office when told they could not be admitted. Surely there could be no better example of poor teamwork. Efficient management cannot be achieved without everyone working together democratically with consideration for one another.

The trustee should recognize his administrator as the executive head of an extremely intricate organization. He should look to him for guidance and counsel on hospital matters. How else can he hope to know what action to take and what policies are sound. He should encourage him to advance professionally, participating in local health and hospital projects and in local and national association activities. A certain amount of outside work is destined to bring added repute to the institution as well as to the individual. The trustee should accord the administrator his confidence and wholehearted support until he is proved unworthy of it.

The administrator, on the other hand, should recognize the board as the governing body, responsible for the financial and professional standing of the institution. He should feel privileged to bring before it his problems, with assurance that he will receive full cooperation and competent advice, individually and collectively. His presentation of these hospital problems should be without bias, with all personal feelings eliminated. He should recognize his responsibilities in educating his trustees on hospital affairs and should feel privileged to speak frankly and to express himself without reservations. Good teamwork implies comradeship —everyone working on an equal footing toward a common goal.

But all this cannot be achieved without leadership. There must be a captain, an intelligent, capable, diplomatic captain. No post holds more problems or more promise of reward than that of hospital president. It has not been given half the recognition it deserves. Some hospital presidents have not given the post half the attention it deserves. And that's another reason why many voluntary hospitals find themselves in such a deplorable state today.

The hospital president, with the administrator, should establish a leadership that will be unquestioned. There should be sympathetic accord between the two, the president assuming full responsibility for effective teamwork among the trustees and the superintendent assuring the loyalty and support of the hospital personnel. It will prove a combination hard to beat.

It *is* proving a combination hard to beat. In one hospital, at least, and there are undoubtedly others, this Utopia has been realized.

This institution had fallen in bad repute. A succession of administrators had introduced conflicting policies which, coupled with a lack of unanimity among the trustees, had contributed to a chronically chaotic state of affairs. Rumor even had it that the institution would soon be obliged to close its doors.

It was finally suggested that outside assistance be obtained, the impartial advice of one who could speak with authority on hospital service. Weeks, months were spent in studying the entire situation, not only its effect on the institution itself but its relationship to the public health program of the community.

There were those on the board, as there always are, who for one personal reason or another were against change. Fortunately, that hospital had a man at its head who was courageous enough to fight, and fight he did, for what he was told on best authority was right.

The board of trustees was reorganized with fewer but better members. There was a change in administration. The president had learned what he should expect of a hospital superintendent.

This was two years ago. Today that hospital is erecting a fine new building and has entered upon a new era of professional accomplishment and service in its community.

Who says the day of the voluntary hospital is over!

Contract for Public Service

THIS AGREEMENT, made and entered into by and between John Doe, hereinafter referred to as the Trustee; and the neighborhood Hospital, referred to as the Hospital.

WITNESSETH:

WHEREAS: The Hospital is in need of public spirited citizens to guide it in its work, to aid it in obtaining friends and supporters and to encourage its workers; and

WHEREAS: The Trustee is desirous of serving his fellow men and wishes to devote a large part of his time and effort to extending the scope and usefulness of the Hospital;

NOW THEREFORE, IT IS AGREED: That the Hospital will at all times, to the limit of its ability, properly serve those who enter its doors, in order that the Trustee may be justly proud of his stewardship; and it is further

AGREED: That the Trustee will serve without any recompense other than his own contentment in serving the community; he will in no wise use his position to promote his own business or that of his friends; he will freely give his counsel and of his knowledge of efficient management, as though the Hospital were his own enterprise; he will do all within his power to better the financial standing of the Hospital and seek the help of his friends and acquaintances for the same purpose; he will use every opportunity to learn the mechanics of hospital management and operation, so that his decisions may be of greater value; and, proud of his opportunity to foster the community welfare, he, by his acts, will add to the Hospital's prestige and create in others a regard for its work. Signed and sealed this first day of March in the year nineteen hundred and forty.

_____ L.S.

For the Hospital

_____ L.S.

Trustee

GREATEST IMPROVEMENT in mattresses *in 100 years*

Many hospitals report the superior comfort of **Airfoam** *mattresses aids recovery in cases of severe shock or injury*

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Handy Man or Engineer?

LUCIUS R. WILSON, M.D.

"Forget that you run a hospital of 475 beds," we wrote Dr. Lucius Wilson. "Pretend you're head of an institution of 50 beds. Then tell us how you would handle the problem of plant maintenance." This article is Doctor Wilson's answer

IT IS only natural that hospital administrators should concentrate on the medical aspect of administration and, in many instances, neglect the care of the physical plant. In large hospitals the problems of plant maintenance are delegated to a chief engineer or building supervisor who has an adequate crew of skilled workmen to look after the property. When the overhead expense of such a department is borne by a large number of patients it does not add tremendously to the per diem cost. Consequently, the physical plants of many large hospitals are fairly well maintained.

There are many such hospitals, however, in which the maintenance could be improved and economies in operation effected if more attention were paid to this phase of administration. A capable building supervisor can easily save many times the difference between his salary and that of a mediocre person. Under good supervision nearly all of the repair work and alterations in the building can be done without employing contract labor, and definite savings can be made in the use of fuel, electricity, gas, steam and water.

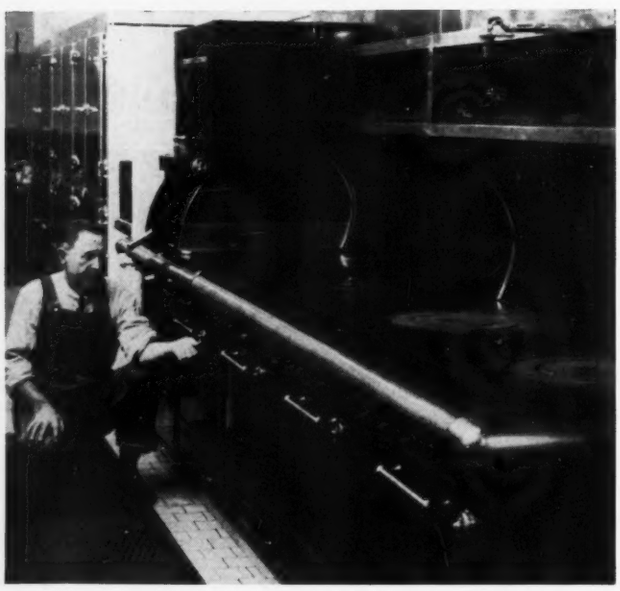
Doctor Wilson is superintendent of John Sealy Hospital, Galveston, Tex.

The administrator of a small hospital often feels that trained maintenance personnel adds an excessive amount to the cost of caring for patients and is inclined to attempt to keep the building and its mechanical departments in good condition through the services of a handy man. Such an individual is often quite adept at making minor repairs but, when repairs and alterations in the mechanical setup are beyond the tinkering field, it becomes necessary to let the work out to contractors. This is expensive because, in order to ensure a profit, contractors must charge nearly double the union hour scale for labor plus a substantial profit on material. The cost of one or more contracts of this nature per year added to the salary of the handy man will run the maintenance expense into a sizable figure. Unless the administrator analyzes such a situation carefully, he will forget what he has spent on contracts and fool himself into thinking that he is maintaining the plant well and at no greater expense than the salary of the handy man plus the cost of a few materials.

The worst feature of this common maintenance arrangement is the inclination to make only the most urgent repairs and to await a complete breakdown of some part of the mechanical plant before correcting the difficulty. This is expensive and often inconvenient.

A motor that is properly cleaned and oiled will serve for years, but without such attention it may burn out in a short time and necessitate the expenses of rewinding. Too high voltage on the electric line will cause light globes to burn out before the normal life expectancy. If the heating plant is properly inspected and conditioned every summer, it will not, under normal circumstances, break down in the winter and cause the inconvenience and the expense of a substitute heating arrangement until the contractor, working day and night with double charges for overtime, can make the repairs.

Nearly every hospital today has an air conditioning apparatus for one or more units. Efficient operation of such apparatus is based upon the maintenance man's knowledge of the mechanism and of the principles involved. Unless he has such knowledge, unsatisfactory results and



Amateur or expert? The handy man may know how to repair a defective kitchen range, or he may just be running up a larger contractor's bill. An experienced engineer can usually make such repairs and save money for the institution in the long run.

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For the basic AMERICAN policy is this—To serve our friends in the hospital field as we should want to be served—and *to ship every possible order the same day it is received.*

AMERICAN regularly catalogs some 8,000 items of hospital equipment and supplies — and has developed many exclusive products that are indispensable in efficient hospital operation.

Whether it be bandages and safety pins, or the complete equipment of a new hospital, AMERICAN is prepared to supply your institution promptly, economically and with assured satisfaction. When in the market, always consult AMERICAN'S Bulletins and Representatives.

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G Entirely new! An *electric motored* suction apparatus that gives fully controlled continuous or intermittent suction at any point from 0 to 15 inches of mercury. The new Tomac Electro-Gastromatic Suction Apparatus is a unit with "a thousand uses". It brings clean, quick, convenient efficiency to relieve one of the most distasteful and time-consuming phases of nursing. Ask the AMERICAN representative to arrange a demonstration for you.

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T AMERICAN has made exhaustive research to provide the finest in hospital thermometers — accurate, easy to read, time and money saving. Multiply these savings by the countless times a thermometer is used — and you will find an important advantage in Tomac Thermometers. Ask our representative about them.

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O Oxygen therapy prevents sulfanilamide and sulfapyridine nausea in a large percentage of cases. AMERICAN'S Oxygen therapy equipment is distinctive in its features—complete—economical. Our new portable Oxygenaire and adjustable rubberized or transparent canopy are ideal for the smaller hospital. Other units to fit every requirement.

frequent breakdowns may be expected.

Painting is expensive and a knowledge of different paints and their uses is essential; otherwise, frequent painting jobs will be required or damage will result to the surface.

Failure to repair steam leaks promptly is another source of waste. Knowledge of fuel, its use and the care of the firebox saves money. All of these procedures are well beyond the knowledge and ability of the ordinary handy man.

The physical plant of even a small hospital is worth many thousands of dollars and the lack of proper care will, in a few years, result in depreciation amounting to a substantial sum of money. Does it seem wise, therefore, to entrust the stewardship of this equipment to an untrained and unskilled man? Obviously not. There are only a few small hospitals wealthy enough to neglect the building and mechanical equipment and to pay the cost of extensive repairs and new installations every few years. Such a "penny wise and pound foolish" policy eventually leads to bankruptcy. A small hospital will employ a well-qualified nurse to direct nursing activities, a properly prepared dietitian to supervise the dietary department, capable technicians for the laboratories and a good accountant to keep the books, but the maintenance man may be anyone from an aged carpenter to an unqualified plumber's apprentice.

While the salary of a capable maintenance man will cause an increase in the pay roll, the savings he will effect will more than offset the additional salary. He need not be a graduate of some university school of engineering, but he should possess sound theoretical and practical knowledge.

These qualifications can be found in a man who has had several years' experience as one of the assistants to the chief engineer of a large hospital. Such a man will be competent and will possess a fund of information that will be manifested in every department. The medical staff will be delighted to have someone who will keep equipment and apparatus in good working condition. Patients and visitors will be impressed with the improved appearance of the buildings and pleased to have all service lines functioning as they should. Hot water from a hot water faucet is taken for granted, but cold water from a leaking or noisy hot water faucet does not arouse favorable comment. It is irritating to have to climb stairs because the elevator is out of order. Weather stripping, when properly installed and maintained, effects an economy in fuel consumption; otherwise, it is expensive because of heat loss and often creates noises that jar everyone's nerves.

These reasons, and many more, emphasize the fact that a good maintenance man will pay dividends on his salary, while the handy man is a definite liability.

Income From Waste

JACOB KATZIVE, M.D.

ALTHOUH hospitals are employing every method known to them to control waste, a certain amount of it is unavoidable. However, this need not represent a complete loss. An appreciable amount in terms of dollars and cents can be salvaged, the amount depending upon the size of the institution and its success in controlling waste. At Mount Sinai Hospital in New York between $2000 and $3000 a year was realized from the salvage of the following items: exposed x-ray films; kitchen waste (grease, bones, butcher's fat, entrails); garbage (food waste); gold, silver and platinum; alcohol drums; barrels; old rubber; potato bags; hampers; scrap iron; paper, and magazines.

Discarded Exposed X-Ray Films: Discarded films may be sold to concerns that specialize in the reclamation of the silver contained in the film. In recent years the clear film that remains after the emulsion has been washed off has found a ready market among those who use it for the purpose of manufacturing novelties, such as gift boxes, cake covers, microscope covers and numerous Christmas gifts. For this reason, it is advisable to sell the x-ray film several months before the Christmas season begins, that is, late September or early October. These films bring from 10 to 23 cents per pound, depending upon the market and the location of the source.

Grease: Soap manufacturers use vegetable and animal oils. Kitchen grease, which is a source of animal oil, is in demand and may be sold for from 3½ to 6 cents per pound, also depending upon market conditions. If one takes the trouble to separate the clear grease from butcher bones, fat and entrails, a greater income from the same total quantity will result. Bones, meat scraps and entrails sell for only ½ to 1½ cents per pound, while butcher's fat sells for 3 or 4 cents per pound. The bones and entrails are ground into fine particles and sold for chicken feed and fertilizer.

Garbage: Garbage, consisting of left-over food and vegetables, may be sold to hog raisers who use this as food for hogs. Some concerns will agree to take garbage or swill on an annual basis. They will furnish containers with covers for this purpose. Incidentally, considerable quantities of table silverware that may have been inadvertently discarded are often recovered.

Gold, Silver and Platinum: A small income may be derived from old gold, silver and platinum recovered from extracted teeth of patients in the dental clinic. Occasionally, these metals are found in valuables left by patients who for some reason did not claim them after a reasonable time had elapsed.

Alcohol Drums, Barrels, Old Rubber, Potato Bags, Hampers, Scrap Iron, Paper and Magazines: In spite of the large number of items represented in this group, the returns from these have been rather small. Alcohol drums and barrels lead the list, followed by rubber. The return from the other items up until the present time has been insignificant but with the present European requirements for paper and scrap metal, they should become a greater source of income.

Doctor Katzive is assistant director of the Mount Sinai Hospital, New York.

M. BURNEICE LARSON, DIRECTOR

THIS *One Thing* WE DO . . .

To find one's logical place in the medical field today, one must specialize highly . . . and with specializing comes more complex problems in bringing together the *Place* and the *Person* who can perfectly fill it.

A hospital is a highly specialized organization of trained people who perform many complex duties with fine coordination. To help the hospital or other medical organization find these people who can best serve it . . . and to help administrators, graduate nurses, laboratory workers, dietitians, social workers, pathologists, radiologists, and other physicians who may or may not have specialized—to find their opportunity in the field—is the ONE highly specialized service to which The Medical Bureau has for years devoted itself exclusively.

The Bureau's work is thorough, painstaking, confidential. Its long experience, trained judgment and wide contacts are brought to bear on every problem of placement.

By employing the Bureau, Institutions save the time and expense of examining many applicants—quickly and confidentially make contact with the few who are best qualified.

To Individuals seeking their logical place—their utmost in service and opportunity—the Bureau offers a most important contact with a field which is rapidly growing and *frequently has more places than qualified applicants.*

To each—the Institution and the Individual—the Bureau offers its assistance—to help analyze requirements—and ability; to help bring together the *Person* and the *Place* . . . May we help you?

The MEDICAL BUREAU

THE CONNECTING LINK BETWEEN MEDICAL ORGANIZATIONS SEEKING HIGHLY QUALIFIED WORKERS, AND SELECTED WORKERS SEEKING CAREERS IN THE MEDICAL FIELD

Palmolive Building, Chicago

Storage and Control of Keys

F. STANLEY HOWE

EVERY hospital, regardless of its size, requires innumerable keys to rooms, cabinets, closets, lockers and furniture, either fixed or movable. Hence, an adequate system of controlling and safeguarding keys is of utmost importance.

At one time I had experience with a system whereby the keys were kept separate from the records. The principal failing of this method was that, too frequently, the individual responsible for the keys neglected to make note on the records of the keys issued and to whom they were delivered. Furthermore, the special nature of the cabinet or other container for the keys made it necessary to anticipate future growth on a large scale or to duplicate special units from time to time.

Finally, we adopted a system of control which we have employed for ten years and which seems to meet every requirement both for completeness of record and for simplicity and economy in expansion.

We had printed a strong manila envelope of a size to fit a 3 by 5 inch card file. On the face of the envelope are spaces on which can be recorded the building, the number of the room or the number of each piece of furniture that is equipped with a separate lock. Owing to the frequency with which desks and other pieces may be moved about from room to room, it is not sufficient to indicate a given movable piece by the number of the room in which it is first installed. A serial number should be allocated to every piece of furniture; this can be stamped above the lock with steel dies and will identify the piece wherever it may be located. This method is recommended as being simple and foolproof.

The manufacturer of the lock and the cylinder number are also recorded as well as the date on which keys are issued, the persons to whom they are given and the dates when keys are turned in or duplicates issued. In actual practice there seems to be no other information necessary.

All duplicate keys are placed inside the envelope, which is sufficiently large and strong to hold as many as four large bit lock keys and even more of the six tumbler cylinder lock keys. These envelopes are then filed in standard 3 by 5 card drawers, which may be obtained in any quantity necessary to meet the requirements of a given institution.

The key file must, of course, be carefully safeguarded. This can be accomplished by placing an adequate lock on the filing drawer units. If standard storage cabinets are available, card file units made to fit inside of them can be used. Each drawer front should be plainly marked to indicate the keys contained within it, and the system can be expanded gradually by adding more filing drawers.

We have found that the system has the following merits:

1. When a key is issued, the envelope is in hand as a reminder to record the fact, without reference to a separate file.
2. Keys contained in envelopes do not rattle, cannot shake off of pins and are unlikely to become mixed.
3. The difficulty of matching a key when the original blank bearing the cylinder number has been lost is obviated because all information in regard to a given key is available at a glance.
4. The envelope affords a permanent record of all persons to whom a given key has been issued, as well as the date of its return.
5. The system may be adapted to all sizes and types of keys, from the small padlock to the heavy bit lock key, whereas in other methods considerable space is wasted, because the equipment has to be made to accommodate the largest keys throughout.
6. Key files can be expanded or contracted readily and are most compact and convenient.

Some institutions are equipped with key cutting machines, because they regard it as an economy to make their own keys rather than to patronize the local locksmith. Unless the administrator operates this himself there is always the possibility that other persons in the institution may take advantage of this machine to make duplicate keys. I doubt if many institutions would save money by keeping a stock of blanks, as against letting the locksmith assume this responsibility, because the great variety of locks that are used in an institution calls for an equal number of blanks.

It is our present practice to send the keys to the locksmith without any means of identification except as to the institution from which they come. An exception is made of master keys, which are ordered direct from the maker, and do not go through the local locksmith. Under this system there is a minimum amount of laxity in the handling of keys.

A typical 3 by 5 card drawer with an inside length of 15 inches will easily hold 130 envelopes containing flat locker keys or 60 envelopes containing from one to four duplicates each of cylinder lock or bit lock keys.

All information regarding the whereabouts of keys to rooms, lockers or furniture may be recorded on these handy envelopes.

KEY RECORD | KEY NUMBER:

BLDG. ROOM: FURN. No.

DATE	RECEIVED BY:	RETURNED	REPLACED

Mr. Howe is director of Orange Memorial Hospital, Orange, N. J.

Duties of Dietitian-Housekeeper

MABLE MacLACHLAN

THE three principal duties of the combination dietitian-housekeeper in a small hospital are as follows:

First comes responsibility of buying, preparing and serving food to patients and personnel. This is a daily activity and, inasmuch as the health and happiness of many people depend on their daily nutrition, a great amount of time and care must be expended on it.

Second comes the supervision of the therapeutic diets, which includes not only carrying out the doctors' orders but giving constant attention to the patient to help him become adjusted to an unusual fare. The patient needs instruction so that he will have a full understanding of his diet and will adhere to it when he leaves the hospital.

Third is the management of the housekeeping department; that is, the responsibility for the cleanliness of the institution and the upkeep of the equipment and linen.

Organize Work Schedule

A well-organized schedule of work is necessary both for the dietitian-housekeeper and for all the employes in her department, if these varied responsibilities are to be handled adequately. Working schedules for each job should list all duties with an approximate time limit for each and should include all special work for each day of the week. Meal hours and time off duty should be stated. The personnel will be happier and more contented if Sundays and special holidays can be rotated. Particular care is required in planning schedules to see that everyone is being fairly treated and, at the same time, that all work is covered.

A chart that shows the number of meals served each day to patients, nurses and personnel during the past year will be of great assistance in planning, preparing and serving the food. Such a chart eliminates the guesswork in ordering and, if proper allowance is made for any general increase or decrease in hospital service, provides a reliable figure for use. A chart of the dinner meats that are to be served during a period of from six to eight weeks prevents undue repetition and affords an even balance of the various meats available, as well as economy in their use.

Standardized recipes and portions serve to eliminate the individual variations that result when different people do the same job; they also help to economize on both food and time. If the dietitian knows how many people she is going to serve and prepares just enough food to serve that number of people adequately, the problem of leftovers will be almost negligible.

A monthly inventory of all movable equipment assures the sorting and discarding of dishes and equipment that are no longer usable or up to standard; furthermore, it reveals any carelessness or negligence on the part of the personnel. A depreciation fund that covers all large pieces of equipment will ensure their replacement at the end of their allotted period of usefulness. If all pieces of equipment are dated and marked for the particular unit in which they are to be used, it will help tremendously in keeping equipment where it belongs.

A diet manual comprising the standard diets used by the hospital often will eliminate a multiplicity of diets when one will serve all purposes. It will permit the doctor to know what foods are being provided for his patients and will serve as a basis of understanding between the dietitian and the doctor.

The fundamental decision that must be made regarding the housekeeping is the division of responsibility between dietetics-housekeeping department and the nursing department. The division of duties will vary with the individual institution. A system that has proved successful in one hospital is as follows: the nursing department is responsible for all movable equipment and the department of dietetics and housekeeping is responsible for the cleaning of all stationary equipment, *i.e.* windows, walls and floors.

Prevent Overlapping Duties

Even with this broad division, there is likely to be some overlapping. To prevent misunderstanding and to ensure that all points are covered the duties and responsibilities of each department should be written down and each department should have a copy. This procedure settles such questions as who should see that the brass on the refrigerator is shined or who should clean the floor under the bottom shelf in a closet.

A chart of the days on which walls and windows are washed will tell at a glance where to send the workers at any given time and will furnish reliable evidence when the floor nurse calls to say that the windows in her ward have not been washed for six months.

In any institution, regardless of type of construction or cleanliness, some one person must be responsible for the extermination of pests. In view of the many types of produce and equipment that are being received daily, mice and roaches are sure to be brought into the hospital. The housekeeper is naturally the person responsible. One worker should be assigned the duty of spraying all the building with a vermicide as part of a routine schedule. In addi-

The author is director of the department of dietetics and housekeeping, University Hospital, Ann Arbor, Mich.

tion, every member of the staff should cooperate to prevent these pests from invading the hospital.

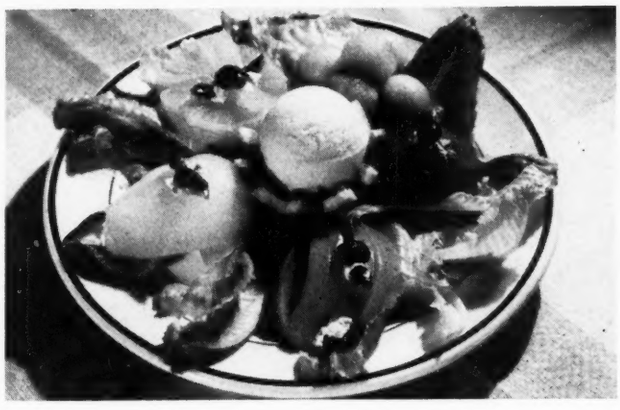
All cleaning supplies should be standardized and charts kept of the amount issued to each worker. If a check list of the equipment is kept in each janitor's closet, it is a simple matter to see that everything is in its place and in good order.

The management of the laundry and of the linen supply may very possibly be the responsibility of the dietitian-housekeeper. Linen has a habit of disappearing and needs careful checking. A standard amount of flat linen may be set up for each bed. For instance, the number of sheets in each set would be estimated as follows: two on the bed, one in the linen closet, one at the laundry and one in transportation, making a total of five sheets necessary for each bed. As sheets wear out they should be counted and replaced with new ones, thus keeping the total number up to standard. A complete inventory should be taken at least every six months as a check.

The responsibility for the general upkeep and repair of equipment and furniture should be shared by the engineer and housekeeper.

All employes should be given a thorough physical examination, preferably before they have been definitely employed, but always within a week afterward. This is especially necessary for all food handlers and at stated intervals a checkup should be made by means of a blood test and chest x-ray examination.

"The Salad, Please"



A fruit salad plate that is designed to tempt the most jaded palate. It consists of peach, pear, plum, pineapple and melon, topped with a scoop of lemon ice.

GREATER imagination in their preparation has brought salads into prominence on hospital menus. Dietitians have discovered that the patient to whom other dishes are unappetizing will frequently succumb to the lure of a crisp fresh looking salad. In the employes' dining rooms, too, it has its own undisputed place. It may be only a side dish but at times it is a major item that wins unqualified approval.

Even men to whom the word "salad" was formerly synonymous with femininity have long since changed their opinion. A salad can be as much a man's dish as a woman's. Heartier ingredients and tangier, heavier dressings are the answer.

It is no longer true that salads are warm weather fare, only to be served when the gardens produce all manner of green edibles that have no place elsewhere than in the salad bowl. The modern salad is just as important on the coldest day as on the hottest. It furnishes food values which are essential to the well-balanced diet and which cannot be obtained as appetizingly in any other way.

Many hospital dietitians take great pride in the variety they are achieving in their salads. It is even demanded of them. It was not so long ago that a hospital superintendent who was selecting a new executive dietitian made it a requisite that she must provide variety in salads. Apparently he was successful for at the end of the year he was heard to remark that his new dietitian "must sit up nights thinking up salads because she hasn't duplicated once."

It is interesting to visit a few of these kitchens where salads are in the making and to talk with the dietitians who have been instrumental in divorcing salad from its common appellation of "grass" and surrounding it with glamour.

In the kitchen of Memorial Hospital, Worcester, Mass., for example, Helen MacLean is injecting variety into her salads by using unusual salad greens, such as Belgium endive, chicory, kale, romaine and watercress; she also uses all manner of garnishes, including fruits and vegetables in season. The most popular items on her long list are a salad bowl; club fruit plate comprising oranges, cottage cheese, dates and nuts, and fresh fruit salads. Gelatine salads are always popular with the patients, she finds, and fish salads, such as tuna and salmon, are favorites in the dining rooms. Her best liked dressings are Roquefort cheese, Russian, French chiffonade and what she terms "golden," which is whipped cream with fruit juice added to it.

At Stanford University Hospitals, San Francisco, Charlotte Sloan serves a simple salad with the main meal. This may be asparagus with mayonnaise, artichoke with mayonnaise, salad bowl, lettuce heart with Roquefort cheese dressing (extremely popular), celery with French dressing and anchovies and celery hearts and carrot sticks. It is on the supper menu at night, however, that salads assume a major rôle. These are usually large and elaborate: combination fruit, for example, or vegetable or molded gelatine.

This is not all. "Besides having salad on the menu for both meals," Miss Sloan explains, "we make about 40 salads on special order each day. We have more than 200 recipes for salads all of which we use, besides the innumerable combinations we make up according to the food on hand or the whim of the patient.

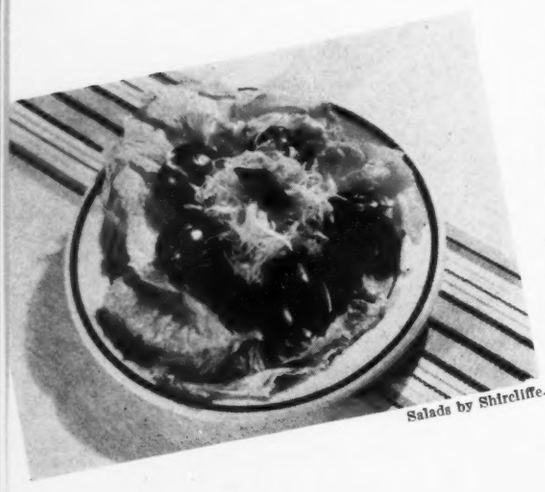
"Our rules for making salads are simple. The plate must be large enough so that the lettuce or other garnish will not fall over the edge. In other words, the rim of the plate must show. All greens must be washed, put in ice water until crisp and then dried and kept in the

icebox until used. Special order supper salads, which we have to make up in the morning, must not be marinated. No dressing is put on these salads until serving time because dressing wilts the salads when they stand. We try to have all liquid dressings put on in such a way that they will not run freely on the plate.

"We encourage our salad makers to decorate their salads as originally as possible, with the exception of the salads on the menu. A sample of every salad on the menu is made every day. The maids in the service kitchens are expected to make their salads like the sample. It is amazing, even with this precaution, how different they look in the different kitchens.

"Mayonnaise made with cottonseed oil is our most popular dressing, but French and Roquefort cheese dressings are also well liked. For fruit salads, we use mayonnaise and whipped cream, half and half. For all French dressings and dressings on a French dressing base, we use California olive oil. We are proud of our mayonnaise and we continually have requests for our recipe and for the brand of oil. We are also proud of our mineral oil mayonnaise, as it is palatable enough to use even with hot artichokes."

Tomato salad ranks first in popularity at Montefiore Hospital, New York, according to Lenna F. Cooper, with tomato and cucumber, spring salad and fresh fruit salads ranking close. Miss Cooper uses water cress and lettuce for garnishing. She finds that cream mayonnaise is the most popular dressing for the fruit salads.



Salads by Shircliffe.

Right: Balls of melon on a thick slice of tomato from which the pulp has been removed, bordered with cream cheese and garnished with cress. Below: Coleslaw garnished with cherry tomatoes that have been cut in quarters and filled with cream cheese.

Here are some interesting suggestions revealed by Genevieve Coon, assistant dietitian at Albany Hospital. She finds that cold plate combinations are very popular with the staff. "These are in no sense a use of leftovers," she declares, "but are a carefully selected combination of well-seasoned and flavored salads, cheese, vegetables and relishes. To make the salads attractive, great care is exercised in arrangement on the plate as to colors, textures and garnishes."

Some of the combinations that may appear on a typical cold plate are as follows: (1) cardinal salad, which is beet and celery diced finely in lemon gelatine; (2) shell of a half lemon filled with a mixture of sardine and egg garnished with stuffed olive; (3) sliced tomatoes; (4) celery stalk stuffed half with plain cream cheese and half with pimiento cream cheese; (5) ripe olives; (6) Italian salad, comprising potatoes, anchovies, dill pickles, ham and apple; (7) sliced white meat of chicken or turkey.

"An endless variety of combinations which reflect ingenuity and artistic skill may be used," states Miss Coon. "One of the more popular salad dressings for use with plain lettuce is horse-radish mixed with mayonnaise."

Nothing sets an attractive salad off to better advantage than a green glass plate with divisions. "It looks particularly cool and inviting to the patient in the summer time," Irene L. Willson, chief dietitian at Shadyside Hospital, Pittsburgh, tells us.

Among the salad combinations in which Miss Willson specializes are: (1) tomato wedge, water cress, Frenched green beans and pineapple gems; (2) raw shredded carrot and celery, hard cooked eggs, tomato wedge, asparagus tips, sharp cream cheese; (3) molded black cherry salad, Philadelphia cream cheese, date bread, celery curls; (4) tomato aspic ring filled with fresh crabmeat, quartered hard cooked eggs, nut bread; (5) stuffed pear molded in lime gelatine, Swiss cheese, cold baked ham, olives.

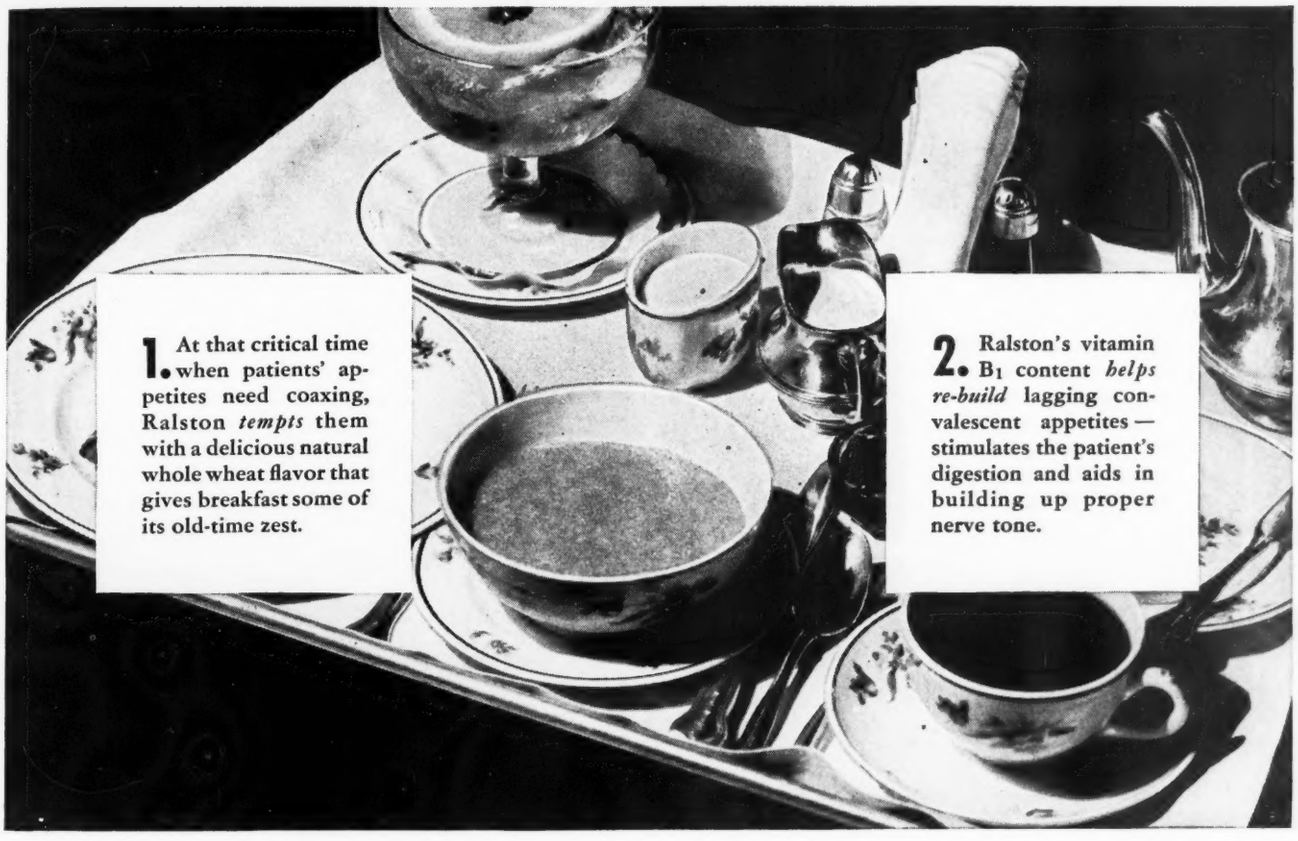
At Lenox Hill Hospital in New York, Harriet M. Wells makes good use of the avocado, or alligator pear. She uses it with grapefruit and white grapes and also stuffs it with lobster or crabmeat salad. Other popular salads in this hospital are fresh fruit with cream dressing and pear-macaroon. Miss Wells finds that French and Russian dressings are the most popular.

"Our fruit salads are always in demand," states Crystal Roney, dietitian at the Atlantic City Hospital, Atlantic City, N. J. "These are made up of suitable combinations of fruits, arranged attractively on lettuce, endive or chicory with strawberries or cherries as a garnish. Sometimes melons are cut in rounds and filled with other fruit.

"Mint leaves always freshen the salad," Miss Roney adds. "Of course, the real worry in summer is to serve the salad crisp and fresh to the patient. We find that French dressing is more popular than any other."

Elizabeth Rugh, chief dietitian of the Veterans Administration facility, Bronx, N. Y., mixes her salads in small quantities so that they will not be crushed or appear to be care-

This natural wheat cereal meets two important needs of fussy *Convalescent appetites*



1. At that critical time when patients' appetites need coaxing, Ralston *tempts* them with a delicious natural whole wheat flavor that gives breakfast some of its old-time zest.

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Ralston is made from whole wheat naturally enriched with added wheat germ for extra vitamin B_1

More and more hospital dietitians are realizing the important place Ralston Wheat Cereal occupies in the hospital diet list. A delicious, easily digested hot cereal made from whole wheat, it supplies: (1) carbohydrates; (2) important proteins; (3) valuable iron and phosphorus; (4) natural bulk.

In addition, Ralston has been enriched with natural wheat germ which makes its vitamin B_1 content *more than twice* that of whole wheat. A serving of Ralston (1 oz.) provides 65 I. U. of vitamin B_1—essential in both convalescent and normal dietaries.

RALSTON WHEAT CEREAL
ANALYSIS IN GRAMS
30 grams (1 oz.) *Dry* Ralston

	GRAMS
Fat	.51
Protein	4.5
Carbohydrates	21.0
Ash	.5
Iron	.0012
Calcium	.015
Phosphorus	.12
Manganese	.0012
Copper	.00018

106 Calories

30 grams Ralston Wheat Cereal contains 65 International Units vitamin B_1. Ralston is a rich source of vitamin E and a good source of vitamin G.

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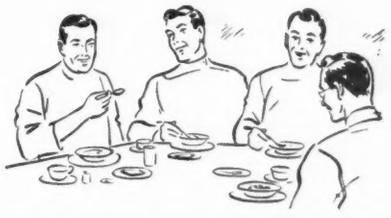

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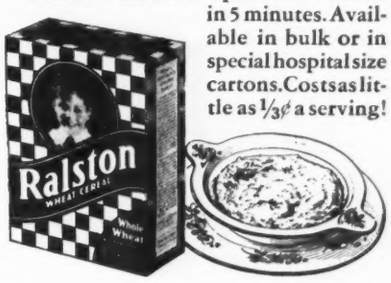


RALSTON WHEAT CEREAL

lessly prepared. Fresh fruit or vegetable salads she serves in slices, pieces or whole. Instead of being marinated, they are served with the dressing in a separate dish. Fresh shrimp, crabmeat, flaked cod or haddock salads, as well as tuna fish with rice and celery, are among Miss Rugh's favorites. Salmon with cubed cucumbers and salted unbroken halves of English walnut meats tossed lightly; chicken, cubed lamb, peas and celery; cubed baked ham, cucumber and celery, and cubed boiled beef and celery with green pepper rings are also included on her list.

Ruth Edwards, assistant dietitian at Strong Memorial Hospital, Rochester, N. Y., varies her salads with fruits, vegetables, cheese, fish, eggs and gelatin. Most popular on her list are deviled egg, fruit, tomato and cucumber, banana and nut, German potato, coleslaw, crabmeat, chicken, cream cheese with chives, stuffed fig and Waldorf. She makes these attractive by the introduction of freshened greens, neat arrangement and color spots. Her most popular dressings are Roquefort, Russian, Thousand Island, horseradish and fruit French.

Fruit salads come first in order of popularity at St. Luke's Hospital, New York, according to Mary R. Curfman, supervising dietitian, with assorted greens and fresh vegetable second and third on the list. Mayonnaise is the least popular dressing; French dressing tops them all with Thousand Island second on the list and Roquefort cheese and fruit salad dressing third and fourth.

These suggestions picked up here and there may be amplified many times over by the experiences throughout the country of other hospital dietitians who are experimenting daily with new combinations and ideas. Perhaps some of them will be glad to let the editors hear of new salads they have originated that are proving popular. An exchange of ideas is always stimulating.

In the meanwhile, here's to better and more glamorous salads!

Food Cost Tables—Staples

GRACE S. SAUNDERS

The tables giving the costs of preparing vegetables will be resumed when the data on the series are complete.

BAKING POWDER

COSTS, AS PURCHASED

1 lb.	.15	.175	.20	.25	.275	.30	.32	.34	.35	.36	.38	.40	.42	.44	.46	.48	.50
1 oz.	.0093	.0109	.0125	.0156	.0171	.0187	.02	.0212	.0218	.0225	.0237	.025	.0262	.0275	.0287	.03	.0312
1 C (6.15 oz.)	.0576	.0673	.0769	.0961	.1057	.1153	.123	.1307	.1346	.1384	.1461	.1538	.1615	.1692	.1769	.1846	.1923
½ C.	.0288	.0337	.0385	.0481	.0529	.0577	.0615	.0654	.0673	.0692	.0731	.0769	.0808	.0846	.0885	.0923	.0962
¼ C.	.0144	.0169	.0193	.0241	.0265	.0289	.0308	.0327	.0337	.0346	.0366	.0385	.0404	.0423	.0443	.0462	.0481
1 T.	.0035	.0041	.0048	.006	.0065	.0071	.0076	.0081	.0083	.0086	.0091	.0096	.01	.0105	.011	.0115	.012
½ T.	.0018	.0021	.0024	.003	.0033	.0036	.0038	.0041	.0042	.0043	.0046	.0048	.005	.0053	.0055	.0058	.006
1 t.	.0012	.0014	.0016	.002	.0022	.0024	.0025	.0027	.0028	.0029	.003	.0032	.0033	.0035	.0037	.0038	.004

Baking powder is available in No. 10, No. 5, No. 1 and No. ½ cans.

BAKING SODA

COSTS, AS PURCHASED

1 lb.	.02	.03	.04	.05	.055	.06	.065	.07	.075	.08	.085	.09	.095	.10	.105	.11	.12
1 oz.	.0012	.0018	.0025	.0031	.0034	.0037	.004	.0043	.0046	.005	.0053	.0056	.0059	.0062	.0066	.0068	.0075
1 T.	.0004	.0007	.001	.0012	.0013	.0014	.0016	.0017	.0018	.002	.0021	.0022	.0023	.0024	.0026	.0027	.003
1 t.	.0001	.0002	.0003	.0004	.0004	.0005	.0005	.0006	.0006	.0007	.0007	.0007	.0008	.0008	.0009	.0009	.001

Gram Weights: 1 T = 11.28 grams. Baking soda is available in 1 lb. and ½ lb. packages.

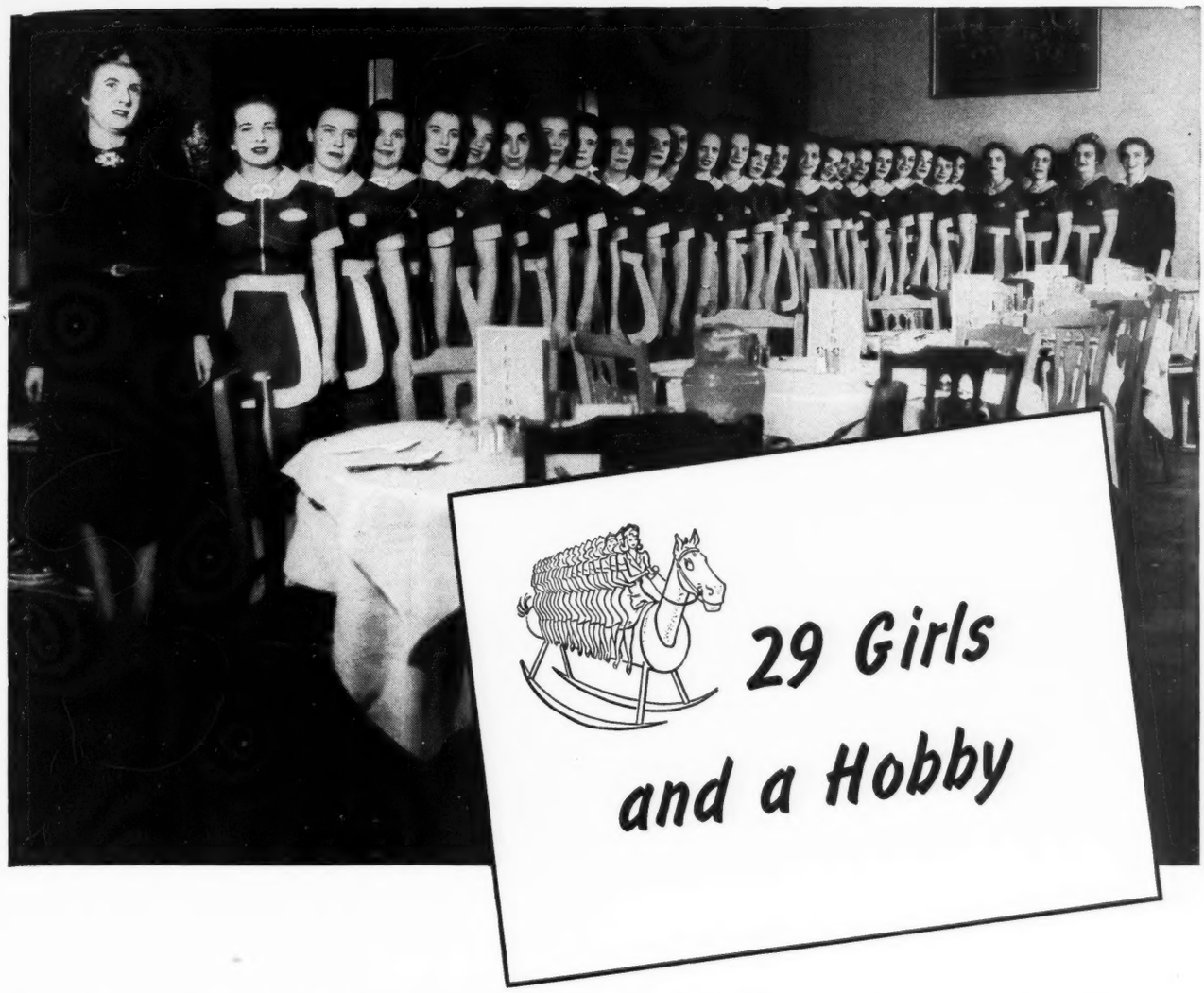
CREAM OF TARTAR

COSTS, AS PURCHASED

1 lb.	.24	.25	.26	.28	.29	.30	.31	.32	.33	.34	.35	.36	.37	.38	.39	.40	.42
1 oz.	.015	.0156	.0162	.0175	.0181	.0187	.0193	.02	.0206	.0212	.0218	.0225	.0231	.0237	.0243	.025	.0262
1 T.	.0057	.006	.0062	.0067	.0069	.0071	.0074	.0076	.0079	.0081	.0083	.0086	.0088	.0091	.0093	.0096	.01
½ T.	.0029	.003	.0031	.0034	.0035	.0036	.0037	.0038	.004	.0041	.0042	.0043	.0044	.0046	.0047	.0048	.005
1 t.	.0019	.002	.0021	.0022	.0023	.0024	.0025	.0025	.0026	.0027	.0028	.0029	.0029	.003	.0031	.0032	.0033
½ t.	.001	.001	.0011	.0011	.0012	.0012	.0013	.0013	.0013	.0014	.0014	.0015	.0015	.0015	.0016	.0016	.0017
¼ t.	.0005	.0005	.0006	.0006	.0006	.0006	.0007	.0007	.0007	.0007	.0007	.0008	.0008	.0008	.0008	.0008	.0009
⅛ t.	.0003	.0003	.0003	.0003	.0003	.0003	.0004	.0004	.0004	.0004	.0004	.0004	.0004	.0004	.0004	.0004	.0005

Gram Weights: 1 T = 10.89 grams. Cream of tartar is available in 1 lb., ½ lb., ¼ lb. and ⅛ lb. tins.

These tables furnish a simple method of comparing the cost per serving of foods in various forms. It was not possible to include labor costs involved in preparing some of the foods, hence, the tables should be corrected accordingly. For a more detailed explanation of the tables, see page 100 of the February issue of The Modern Hospital.



29 Girls and a Hobby

TO THESE WAITRESSES who cheerfully serve the patrons in the main dining room of Fried's Restaurant in Philadelphia, working at a hobby is no leisure-time diversion.

It's their job!

For at Fried's, everyone from the chef to the cashier lines up behind scientific menu planning . . . a hobby Mr. Emil J. Fried originated 30 years ago, and which his sons, Joseph A. and Maxwell B. Fried, still pursue.

Because they wanted garden-fresh and full-flavored fruits and vegetables *at all times* . . . within the bounds of their food-overhead allowance . . . Fried's Restaurant began using Birds Eye Frosted Foods five years ago.

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"Through using Birds Eye Frosted Foods, we have been able to improve our quality through uniformity of merchandise throughout the year, and cut the costs of doing business because of the work saved in the preparing of these products."

The "uniformity of merchandise" the Messrs. Fried point out is the BIG PLUS Birds Eye has over all other foods. Birds Eye Fruits and Vegetables are *Quick-Frozen only 1/4 short hours after picking!* This miracle process *seals in* country-freshness . . . holds it in till the foods are served, summer *or* winter!

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By consistently specifying Birds Eye's 30 food items on your menus, you will experience a new ease in fixing your portion costs in advance. Yes, and at a new, LOWER, served-cost figure!

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Call your local Birds Eye man today. Ask him for complete information on these remarkable, profit-bringing foods. Or, write . . .

In season and out—over 2 dozen kinds for menu variety

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Jumbo Asparagus Tips
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Broccoli
Brussels Sprouts
Cauliflower
Corn-on-Cob
Cut Corn, Golden Bantam
Cut Corn, Country Gentleman
Green Beans—1/2" cut
Green Beans—French Style
Green Beans—Whole
Wax Beans—1/2" cut
Baby Green Lima Beans
Fordhook Lima Beans
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Peas
Spinach
Squash
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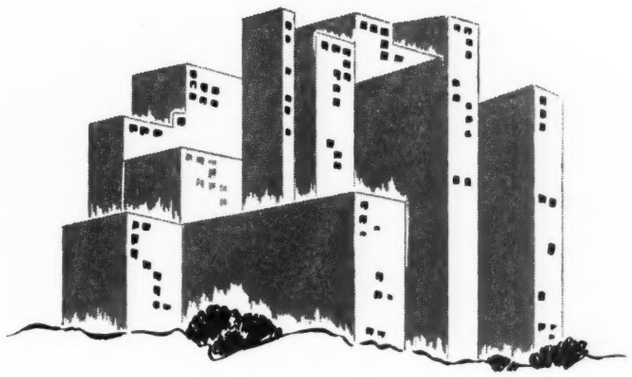
Dietitian, Bloomington Hospital, Bloomington, Ind.

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Fresh Rhubarb	Scrambled Eggs	Cream of Celery Soup	Ham Salad on Parkerhouse Rolls		Tomato Salad	Canned Pears
2.	Grapefruit Juice	Bacon Strips	Tomato Bouillon	Macaroni and Cheese		Shredded Lettuce	Fruited Gelatin
3.	Stewed Prunes	Poached Eggs on Toast	Cream of Potato Soup	Tuna Fish and Noodle Casserole		Peach Salad	Layer Cake
4.	Pineapple Juice	Grilled Ham	Vegetable Soup	Baked Eggs in Potato Puffs		Pea, Cheese and Celery Salad	Canned Plums
5.	Cantaloupe Section	Shirred Eggs	Noodle Soup	Stuffed Baked Peppers		Cabbage Salad	Chocolate Cookies
6.	Half Grapfruit	Fluffy Omelet	Cream of Mushroom Soup	Creamed Chipped Beef on Toast		Apricot Salad	Flaked Gelatin With Cream
7.	Kadota Figs	Canadian Bacon	Barley-Beef Soup	Steamed Rice		Salmon Salad	Strawberries
8.	Stewed Apricots	Poached Eggs	Cream of Lima Bean Soup	Fresh Vegetable Plate: Cauliflower, Asparagus Tips and Grilled Tomato		Cottage Cheese Molds	Orange Ice
9.	Seedless Grapes	Bacon Strips	Tomato Juice Cocktail	Frizzled Ham Slice	Baked Sweet Potato	Fresh Watercress in Oil Dressing	Cream Puffs
10.	Fresh Rhubarb	Scrambled Eggs	Chicken-Rice Soup	Creamed Asparagus on Toast		Stuffed Prune Salad	Baked Apple
11.	Stewed Prunes	Eggs in Shell	Cream of Corn Soup	Spaghetti With Mushroom Sauce		Green Bean Salad	Melon Slice
12.	Orange Juice	Canadian Bacon	Chilled Bouillon With Lemon	Goldenrod Eggs on Rusk		Lettuce and Endive Salad	Sponge Cake With Pineapple Sauce
13.	Fresh Applesauce	Poached Eggs	Cream of Tomato Soup	Potatoes au Gratin		Mixed Fruit Salad	Baked Custard
14.	Grape Juice	Scrambled Eggs and Ham	Vegetable Soup	Cream Cheese on Nut Bread		Cardinal Salad	Fruit Cup
15.	Blueberries	Bacon Strips	Cream of Celery Soup	Escalloped Eggs		Pineapple Salad	Vanilla Ice Cream and Wafers
16.	Stewed Apricots	Fluffy Omelet	Chicken-Noodle Soup	Grated American Cheese on Stuffed Baked Potato		Cauliflower and Pea Salad	Pear Halves in Raspberry Gelatin
17.	Grapefruit Juice	Shirred Eggs	Cream of Asparagus Soup	Baked Corn Soufflé		Shredded Lettuce	Icebox Dessert
18.	Sliced Peaches	Eggs in Shell	Fresh Fruit Cocktail	Creamed Peas and Tuna on Toast Points		Celery Hearts	Marble Cake
19.	Fresh Applesauce	Soft Scrambled Eggs	Cream of Mushroom Soup	Cold Baked Ham		Potato Salad	Blueberries, Vanilla Wafers
20.	Stewed Prunes	Bacon Strips	Clear Tomato Soup	Toasted Cheese Sandwich		Apple Salad	Butterscotch Pudding
21.	Orange Slices	Poached Eggs	Cream of Potato Soup	Escalloped Eggplant and Bacon Strips		Tomato Sections	White Cherries
22.	Kadota Figs	Canadian Bacon	Vegetable Soup	Rice in Milk		Sliced Egg Salad	Bunch of Grapes
23.	Tomato Juice	Eggs in Shell	Chicken Gumbo	New Asparagus en Casserole		Grapefruit Salad	Raspberry Sherbet
24.	Seedless Grapes	Codfish Balls	Cream of Celery Soup	Scrambled Eggs With Jelly		Combination Salad	Canned Apricots
25.	Grapefruit Juice	Shirred Eggs	Clear Consommé	Lima Bean Casserole		Pear and Cheese Salad	Burnt Sugar Cake
26.	Sliced Peaches	Fluffy Omelet	Melon Balls	Baked Idaho Potato		Shrimp Salad	Bavarian Cream
27.	Pineapple Juice	Bacon Strips	Cream of Pea Soup	Escalloped Oysters		Celery and Green Pepper Strips	Boston Cream Pie
28.	Grapefruit Sections	Poached Eggs	Vegetable Soup	Assorted Sandwiches: Peanut Butter, Egg Salad and Jelly		Stuffed Tomatoes	Canned Plums
29.	Stewed Apricots	Eggs in Shell	Grape Juice	Veal Loaf	Escalloped Potatoes	Head Lettuce, Thousand Island Dressing	Peach Shortcake
30.	Orange Juice	Creamed Chipped Beef on Toast	Cream of Potato Soup	Cheese Soufflé		Peach Salad	Chocolate Pudding
31.	Fresh Rhubarb	Shirred Eggs	Rice and Celery in Beef Broth	Spaghetti With Tomato Sauce		Stuffed Egg Salad	Fresh Strawberries

Recipes will be supplied on request by Anna E. Boller, The Modern Hospital, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.



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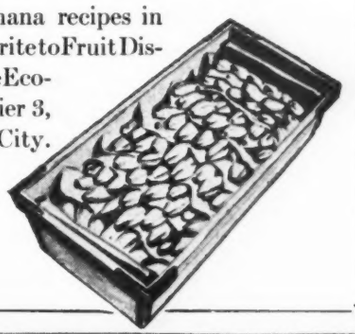
If you haven't tried boxed bananas yet, why not specify them when placing your next order? When you receive your bananas, place them in a room with a comfortable temperature (65 to 70° F.) and let them ripen completely until the golden peel is flecked with brown and the pulp is mellow.

Today bananas are used by hospitals and institutions in numerous special diets and served in many tempting ways. This bland, nourishing fruit, well-liked by most people, contains vitamins A, B_1, C and G as well as many important minerals. It thus helps protect against deficiency in the diet.

For free tested Banana recipes in quantity proportions, write to Fruit Dispatch Company, Home Economics Department, Pier 3, North River, New York City.



Include BANANAS on your menus regularly for both Patients and Personnel { **Few foods give so much value for your money!**

Summer Planning Pays

DORIS DUNGAN

IN considering the important subject of a summer schedule for the housekeeping department, two words of warning are essential: "Start early." Too many times the evil day is postponed. Summer is weeks, even months off yet, we reassure ourselves, and the first thing we know vacations are at hand with no definite plans as to how the necessary painting, renovating and refinishing can be accomplished with a depleted staff.

What exactly is meant by "starting early"? This question can best be answered in terms of the individual hospital. So much depends upon its size, type of service and policies regarding vacations. It would be wise, however, if all preliminary arrangements were made in the early spring, surely no later than the middle of April.

The first step should be a complete tour of inspection by the engineer and the housekeeper during which copious notes are made of needed repairs and alterations: a room to be repainted here; a floor to be scraped there; ceilings to be patched; window cords to be replaced, and furniture to be cleaned and re-upholstered.

Next comes the matter of setting an approximate time for the completion of these repairs so that the vacation schedule can be built around the peak work of this plan. Incidentally, in considering the remodeling work to be done, it is expedient to place first on the list the places that are most conspicuous or that are slated for new furnishings. Nothing like putting our best foot forward. Besides, such procedure releases usable older furniture to be refinished for other locations.

In order to accomplish this inspection effectively, whether it is done by the housekeeper alone or in the company of others, a chart should be used. The accompanying forms illustrate a simple method of checking necessary repairs and renovations for walls, woodwork and window treatments. It will be noted that space is provided for noting the rooms in which repairs are to be made.

When it comes time to inspect the furniture, it is convenient to use a code for the various pieces, such as "D" for dresser and "C" for chest of drawers. The following are some suggested headings that may be changed to meet local needs: "polish," "repair scratches," "repair and reglue joints," "refinish as at pres-

Mrs. Dungan is executive housekeeper at West Jersey Homeopathic Hospital, Camden, N. J.

Chart for Checking Walls and Woodwork

Wall Covering	*Room No.*	*Painted Walls*	*Room No.*	*Ceilings*	*Room No.*	*Wood Trim*	*Room No.*
De-spot		Wash and starch		Wash		Wash	
Scrub or clean		Touch up worn spots		Repair and fill cracks		Polish	
Repaste loose corners		Repair and fill cracks		Calcimine		Revarnish	
Repair with new strip		Repaint (no. of coats)		Paint		Paint (no. of coats)	
Re-cover with.....		Replace with wall covering					
Replace with paint							

Chart for Checking Window Treatments

Draperies	*Room No.*	*Glass Curtains*	*Room No.*	*Venetian Blinds*	*Room No.*	*Shades*	*Room No.*	*Cornices*	*Room No.*
Dry clean		Turn end for end		Dust		New pulls		Cut down and modernize	
Wash		Rehem		Wash		Scrub			
Rebind		Wash and mend		Launder strip and restring		Turn end for end		Replace with modern	
New edging		Replace				Rehem			
Rel-ne				Repaint				Add new	
Transpose center edges to wall		Dye						Wash and polish	
Replace								Repaint	

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* Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk, C. LORING JOSLIN, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

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ent," "remodel," "scrape down and wax," "repaint," "replace with new," "add new pieces" and "remarks." Through the use of the code it is simple enough to include on this sheet the important information that in room 502, for example, we are to polish a dresser, replace an arm chair or refinish a mirror.

The same procedure applies to upholstered furniture in case it is segregated. Here the operations will be "mothproof," "de-spot," "dry clean," "scrub," "repair edges and retack," "re-cover arms," "re-cover back," "re-cover seat," "re-cover entire piece," "slip cover," "repair or replace springs," "repair filling," "remodel and modernize lines," "re-cover with —(specify type of fabric)," "replace with new" and "remarks."

After a careful inspection has been made and the information gathered and assembled in such form that we know precisely what is to be done, the next question that confronts us is how to accomplish it all during the season of the year when vacations are in order. If the budget allows for vacation relief workers, the problem is simplified; but many times the only way that paid vacations can be managed is for everyone involved to double up to fill the gap in the lines. Of course, in some of the bigger institutions, the engineering department takes care of all repairs, painting and remodeling while the housekeeping department merely cooperates in the final cleaning and rearrangement after the actual work has been completed. In the majority of hospitals, however, the major responsibility rests with the housekeeping department.

Again, it is best to be systematic and by aid of a form to ascertain precisely what we have to work with. This form should list the weeks available for vacation with space for the number of people who can be away at one time, the employe being permitted to fill in the time of his choice. A form that gives the choice of vacation in order of seniority can also be used. It is necessary to fix the time carefully so that there will always be one worker on a section who is sufficiently familiar with the procedure to guide the relief worker.

Finally, with all the facts before us, that is, what is necessary to be done and what help we have to do it with, we are ready to plan.

We might just as well realize, however, that listing the time for work to be done and being able to do it at that time are two different matters. Hospital work cannot be regulated so easily. Many unexpected emergencies can tie up the maintenance crew; also rooms may suddenly be filled to overflowing at the very time the schedule says "Go Ahead."

In spite of all this, it pays to plan the summer schedule and to plan it long before vacation time arrives.

THE HOUSEKEEPER'S CORNER

Housekeepers' Tri-State Program

• The varied and interesting program for the hospital executive housekeepers' section of the Tri-State Hospital Assembly, May 1 to 3, is expected to attract a large and enthusiastic attendance. The program has been arranged under the chairmanship of Mrs. Mary Blount Anderson, executive housekeeper, Provident Hospital, Chicago.

The first session on Wednesday afternoon will be opened with a talk by Mrs. Alta M. LaBelle, housekeeping director, Michael Reese Hospital, Chicago, on the evolution of various types of mattresses and their care. Mrs. LaBelle's talk will be followed by a demonstration of the composition and form of latex by Ruth Shelbourn, executive housekeeper of Union House at Purdue University, and Bernice Stein, executive housekeeper, Presbyterian Hospital, Chicago. This demonstration will feature a new and improved type of rubber mattress, especially designed for hospital use.

Joseph T. Davis of Chicago will address the Wednesday meeting on the subject of soap chemistry.

The general discussion will be led by Marie H. Neher, executive housekeeper of the University of Chicago Clinics.

On Thursday afternoon a panel round table on the "Correlation of Housekeeping Responsibilities With Those of the Nursing Department" will be led by Mrs. Mildred Page, Henrotin Hospital, Chicago; Mrs. Effie Armitage, North Shore Health Resort, Winnetka, Ill., and Mrs. Opal Manney, St. Luke's Hospital, Chicago. Mrs. Winifred Bradford, Milwaukee Sanitarium, Wauwatosa, Wis., will preside.

Following the round table, Mrs. Mabel R. Rolence, executive housekeeper of the West Suburban Hospital, Oak Park, Ill., and Mrs. Lelia E. Taylor, Hinsdale Sanitarium, Hinsdale, Ill., will discuss the subject of "Asepsis as Practiced by the Housekeeping Department."

Housekeeping problems will also be discussed at two departmental panel round table conferences for all groups and sections of the assembly, which are to be held on Wednesday afternoon and Thursday evening.

Vacations at Albany

• A few years ago in Albany Hospital, Albany, N. Y., the problem of vacations and summer renovation was a comparatively simple one, according to Althea C. Berry, executive housekeeper of the institution.

"The occupancy of the hospital was lighter during the months of June, July and August, so that supply maids and porters were unnecessary. The work of the absent employes could easily be covered by those whose sections were running low. All this has changed, however, in the past few years. There is now no time in the year when the load lessens perceptibly. This means that extra maids and porters have to be put on to handle the extra work during vacations.

"The housekeeping vacation period runs from April 1 to October 30, inclusive. Our policy of giving vacations is, I think, a generous one. The people who have worked one year, beginning with January 1, have one week with pay. After two years of continual service, two weeks with pay is allowed.

"Vacations are scheduled in sequence so that no intervening time is left open. If steady work can be assured, rather than a week of work and a week's layoff, a fair amount of certainty of the same person's remaining all through the season is assured.

"If an employe resigns, his vacation is automatically canceled. Vacations are given to prepare the worker for the work in the future and not as a reward for past service. Fifty per cent of vacation pay is allowed in advance, the rest being paid on the employe's return to work. In the event that the employe does not return at the expiration of the vacation period, he forfeits the balance due."

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THE NATURAL WHEAT HOT CEREAL

Two New Developments in Drugs

JOSEPH C. DOANE, M.D.

HOSPITAL administrators must be constantly alert to new developments in institutional medicine and open to suggestions from their medical staffs in regard to modernizing and improving medical procedures.

Many lay administrators find it difficult to determine whether the new drugs they are requested to purchase will be worth the expenditure or will prove to be merely passing fads. All requisitions for expensive equipment with which to carry out new treatments should, therefore, be referred to the staff committee on scientific work for approval.

Two interesting new drugs, histamine and heparin, have been developed recently. Both of them, curiously enough, represent substances that are normally resident in the tissues of the body and both were developed by physiologists.

Histamine, Protein Derivative

Histamine is a biologic amine derived from histidine, which is one of the end products of protein digestion. It stimulates the secretory activity of the stomach and is more or less commonly employed in the performance of gastric analyses.

When given in toxic doses histamine produces a shock-like condition. Indeed, many believe that the release of histamine as a result of extensive injuries to skin and other tissues is responsible for the shock condition so often observed in patients who have been brought into hospital accident wards.

Histamine is of interest also because it is thought to have a strong causative relationship to such sensitivity diseases as asthma, hay fever and urticaria, or hives. Asthma and hay fever patients are often highly sensitive to this drug, attacks of their maladies being produced when small amounts are injected beneath the skin.

The greatest practical use of histamine, perhaps, is its ability to dilate the blood vessels, which makes it valuable in the treatment of peripheral vascular disease. Diabetic patients are often afflicted with gangrene, which comes from the narrowing or obliteration of the lumen of blood vessels and the stoppage of the blood supply to the hands or feet. There are many other conditions of a nervous nature in which the muscle of the blood vessel walls is thrown into spasm, thus producing approximately the same result. Any drug, therefore, that can be used to dilate blood vessels locally is of value in the treatment of conditions of this type.

Used for Ulcers and Gangrene

Histamine formerly was so expensive that it was exceedingly difficult to obtain in adequate supply for hospital use. From a price of approximately $25 a gram, the cost of this drug has fallen to about $4 a gram. In a 1 to 10,000 solution, one quart costs about 40 cents. In the treatment of any condition that causes a diminished flow of blood to the lower extremities, the solution is driven into the tissues by the proper adjustment of the positive and negative pole of an ordinary galvanic battery.

The investigators who have used either this drug or a similar one called "mecholyl" report splendid results in the healing of intractable leg ulcers and in the improvement of pregangrenous and other states of local malnutrition.

In cases in which gangrene had set in or was threatened, the surgeon's dictum formerly was to amputate above the knee. Within the past few years, however, a test has been developed consisting of the injection of a small amount of 1 to 1000 histamine solution beneath the skin, which reveals the state of circulation in the particular part. This sometimes makes it possible for the surgeon to amputate the leg at a lower level.

Since the eleventh century scientists have noted that in some instances shed blood fails to clot. Many have likewise searched for the reasons underlying the fact that blood remains liquid within the vessels of the body. Why, they wondered, does normal blood clot as soon as it is shed but never become coagulated within the body until a vessel is wounded?

On the other hand, the sudden stoppage of blood flow as a result of an intravascular clot is a frequent cause of death. Hospital accident wards receive many patients throughout the year who suffer from a clotting of blood within one of the heart vessels.

A patient who has undergone an apparently successful major operation sometimes expires without any apparent cause. In the maternity wards, patients who have had normal deliveries are afflicted with sudden and dangerous respiratory symptoms as a result of a clot's being transported from the blood vessels of the pelvis to the lungs. It has been estimated, that blood clots are found in the chambers of the heart of 15 per cent of all patients who die in the hospital from any cause. At least one out of three of those who die from certain types of heart disease is so affected.

Heparin Prevents Clotting

Diseases of the blood vessel walls and any condition that slows the speedy transit of blood through its vessels are likely to produce a clot similar to that which occurs when blood is shed. In 1916 Dr. Jay McLean of Baltimore, who was carrying on some experiments in the isolation of certain phosphatides found in the heart muscle, discovered an extract that had a tendency to prevent blood coagulation. Later, Howell

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HOSPITAL LIQUIDS

of Johns Hopkins University found that this substance was generously resident in liver tissue and he named it heparin from hepar, meaning liver.

For many years this drug was useful only to the laboratory worker in his experimental research on animals. Within the past decade investigators, particularly Best, Scott, Charles, Murray and others of Toronto, have refined and concentrated this substance so that 1 cc. of heparin added to 100 cc. of sterile saline solution is capable of prolonging the coagulation time of the blood from a normal five or six minutes to fifteen or twenty minutes. By increasing the amount of heparin injected to about 1 mg., or 1/60 grain, for every 2 1/5 pounds of body weight, the coagulation time will be prolonged to as much as fifty or sixty minutes if this solution is given by the drip method.

Clinicians were quick to appreciate the possibilities of such a preparation. Jorpes and his followers in Sweden and Best and his co-workers in Toronto have used this substance to prevent postoperative clotting of the blood. In vascular surgery in which large blood vessels are opened for the removal of clots, heparin apparently prevents other clots from forming on suture lines.

Recently this drug has come to the fore in combination with sulfapyridine in the treatment of the streptococcic infection of rheumatic heart valves. Most experienced clinicians agree that heretofore a proved case of this type of infection of the heart valves has never been known to recover. These patients, who usually linger for many months, eventually succumb to exhaustion or some intercurrent disease. Elson and White reported the apparent cure of two such cases in the *Journal of the American Medical Association* of Nov. 16, 1939. If the report of these observers stands the test of time, these cases represent brilliant achievements on the part of the clinician.

One more interesting application has been made of the anticoagulant effect of heparin. Sappington, in the *Journal of the American Medical Association* of July 1, 1939, reviewed the literature on the use of heparin in blood transfusions and reported on 17 transfusions in which heparin was substituted for sodium citrate in keeping the blood liquid. Of even greater interest was the report by this clinician on 40 transfusions in which the donor was given heparin injections. As a result, the coagulation time was greatly prolonged and his blood was withdrawn and injected into the recipient without the addition of any further anticoagulant.

It does not fall within the province of this paper to discuss the clinical possibilities of these observations, but it is appropriate to point out that this new procedure suggests possibilities of radical future changes in this common hospital practice. To inject the anticoagulant into the donor's veins instead of adding it to his blood after it has been drawn certainly is an intriguing practice. If and when the price of heparin is further lowered and when the drug is less difficult to obtain, no doubt greater experience in its use will suggest other interesting and perhaps life-saving applications.

Drug Control Simplified

H. S. HANSEN

WHEN or where does the pharmacist's responsibility for the prescriptions or drugs he has dispensed cease? In all fairness, it should end when the preparation leaves the pharmacy. There are so many opportunities for contamination through careless handling or improper storage that the pharmacist should not be held responsible after the drug is sent to the various floors or departments. It should be his responsibility, however, to check on the ward drug cabinets in order to minimize any hazards that might result from carelessness in handling or storage.

At Grant Hospital, Chicago, we have semimonthly drug inspection of the various floors and departments where drugs are stored. Cabinets are inspected for neatness and cleanliness, and labels and containers are checked for possible relabeling or replacement. Drugs that deteriorate with age are replaced at intervals. To aid floor supervisors and nurses, lists of the various items that should be stored in the refrigerator, as well as drugs that are more palatable when administered cold, are posted on each floor. The proper storage of these drugs is checked during the semimonthly inspection.

In regard to the storage of drugs, I have frequently advocated that student nurses serve in the pharmacy for ten days helping to fill orders. In this way they will become familiar with the drugs that require refrigeration, such as biologicals, vaccines and serums. Furthermore, they will gain valuable experience in handling ampoules, pills, tablets and ointments.

During the inspection, the stock of drugs is checked to see whether we are carrying a larger supply than is necessary. Drugs that have been ordered discontinued by the physician are picked up and credited to the patient or, if this is not possible, as much as can be salvaged is used in our free clinic.

Another method of drug control of interest to the hospital administrator is the drug room inventory. Establishing a hospital formulary helps solve the problem of being overstocked. It reduces duplication to a minimum and prevents the accumulation of "shelf warmers."

Perpetual inventories and complicated stock control records are cumbersome and can result in so much detail that they defeat their purpose. We have a simple system at Grant Hospital to determine whether we are buying in too large or too small amounts. If we believe that an item that is usually bought by the thousand should be bought in lots of 5000, we mark the date of purchase on the package. Then, if the drug moves fast enough, we increase the order. However, we continue to mark the date of purchase on the package to determine how quickly the increased stock is consumed. If the interest on the investment for the time the item is in stock is greater than the saving, we return to the practice of purchasing it by the thousand.

Mr. Hansen is the pharmacist at Grant Hospital, Chicago.

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The Pharmacy Budget

FRANK BERMAN

KEEPING within a budget allowance is the important duty of every city hospital pharmacist. It is undoubtedly the major problem of private hospital pharmacists, too.

The dread of all pharmaceutical budget makers is the ever increasing number of new specialties. They are the unknown factors that upset the best prepared and calculated budgets.

Undoubtedly, many of the new remedies produced by first-class chemical and drug houses have proved valuable, but far too many are issued by wildcat laboratories and are supported by little or no sound clinical observation. It is the latter specialties that consume the budget allowance to the disadvantage of the institution. The ferreting out of such products is worth the time and energy of the medical staff and the pharmacist.

Willard Parker Hospital is a 450 bed institution for contagious diseases in the New York City Department of Hospitals. It is equipped for the treatment of such contagious diseases as scarlet fever, measles, chicken pox, whooping cough, typhoid fever and tuberculosis. The standard medications for all the diseases other than tuberculosis are serums and antitoxins.

Past records of serums and antitoxins purchased are fair guides for budgeting. There are, of course, the dangers of epidemics and seasonal changes in the relative prevalence of any of these diseases. Our serum and antitoxin bills total $1500 per year.

The medical authorities at this institution make every cent go a mile. Salesmen find that, if they have ethically sound propositions, they are given a fair hearing. Small amounts of new drugs are ordered for experimental observation. These are placed on the hospital list only if they meet their claims.

We have an itemized catalog of approved hospital medications that are supplied at the drug room. This catalog serves as a guide for the constantly changing staff of interns.

Interns and staff physicians who come to the hospital with lists of medications that they have been accustomed to prescribing elsewhere are thus enabled to find substitutes.

With the best of care and supervision, surpluses accumulate and some medications become obsolete. These problems are met by the chief pharmacist's office, which receives surplus lists from each institution and submits them to all the other institutions for the purpose of institutional transfers.

Those medications for which there is absolutely no use are exchanged for other products of the same manufacturers or are sold at auction.

Mr. Berman is the pharmacist at Willard Parker Hospital, New York City.

NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology
University of Chicago

Migraine Headache

• In the February issue the mechanics of headaches was reviewed in these columns. The etiology and treatment of migraine headache will be considered this month.

Every physician ascribes a different cause for this physiologic disorder. The endocrinologist blames the endocrines. The allergist claims the patient because of the prevalence of an allergic family history and occasional relief by omission of some food from the diet. The gynecologist thinks of it as menstrual migraine. The general practitioner frequently treats it as a case of food poisoning.

Predisposing factors include the following: (1) relaxation, for attacks often come on the first day of a restful vacation; (2) excitement; (3) going too long without food; (4) carbohydrate intolerance; (5) strong sunlight; (6) lack of coffee.

Relieving factors are: (1) vomiting; (2) pregnancy in the female; (3) hyperthyroidism; (4) jaundice; (5) infections with fever; (6) the menopause in the female; (7) stabilization or elevation of blood pressure.

Several types of treatment will be considered.

1. Ergotamine tartrate (gynergen) was introduced by Lennox and his coworkers at Boston after observing the overactivity of the sympathetic system that is present in many cases. Toxic doses of ergotamine will prevent the augmentor activities of the sympathetic system in cats. To be effective the medication must be given early in the attack, preferably in a dose of from 0.3 to 0.5 cc. (from 0.3 to 0.5 mgm.) intramuscularly or intravenously.

The side actions of the ergot are nausea and vomiting, muscular aches and weakness, constriction in the throat and chest and burning and tingling of the fingers and toes. The use of oral gynergen to prevent the attacks is hardly justified because of the dangers of ergot poisoning. The oral therapy of the acute syndrome is ineffective unless the 1 mgm. tablets are placed under the tongue and are absorbed through the mucous membrane. This method is not nearly as effective as is parenteral injection.

2. Caffeine and aspirin, if taken when the first warnings of an attack are felt, are sometimes effective in preventing it.

3. Phenobarbital in small daily doses prevents the headaches in some cases and increases them in others.

4. Calcium salts tend to reduce the frequency of the attacks but do not reduce the severity of individual headache.

5. Estrogenic substances, if given in small doses in the last week of the menstrual cycle, are sometimes effective in menstrual migraine.

6. Desensitization with small but increasing doses of histamine has recently been advocated by Horton of the Mayo Clinic.

7. The Mayo group has also shown that the breathing of 100 per cent oxygen will reduce the pain and actually abort some attacks in the early stages.

8. Histaminase (torantyl) has been so recently added to the list of remedies that its effectiveness has not been proved.

9. Benzedrine sulfate (amphetamine) in divided doses of from 5 to 20 mgm. daily is also efficacious in preventing attacks.

NEWS IN REVIEW • • • •

New England Hospital Group Changes Name; Debates Accreditation Program

Not only did the members of the New England Hospital Association establish a new record in making their eighteenth annual meeting the best of the series, but they ended up with a brand new name. Henceforth, the New England Hospital Association is to be known as the New England Hospital Assembly.

This action was announced with the election of the new officers who are Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston, president; Dr. Joelle C. Hiebert, Central Maine General Hospital, Lewiston, Me., vice president, and Donald S. Smith, Mary Hitchcock Memorial Hospital, Hanover, N. H., treasurer. Dr. Albert G. Engelbach, director, Cambridge Hospital, Cambridge, Mass., was reelected secretary.

Among the innovations introduced at this meeting was an evening session consisting of a departmental round table cleverly presented and ably conducted by Dr. Wilmar M. Allen, superintendent, Hartford Hospital. The ball room of the Hotel Statler in Boston was crowded with hospital department heads and administrators who listened attentively to the various discussions centering upon housekeeping, laundry management, maintenance, dietetics, purchasing, the power plant, medical records and accounting. Every indication points to the repetition of this feature another year.

The meeting got into its stride with a discussion of the plan instituted by the National League of Nursing Education for accrediting the nation's schools of nursing. Opinion was expressed both for and against such action. "A racket which would be another expense to hospitals already financially burdened and which would give them nothing in return," was the feeling voiced by Dr. Eugene F. Walker, superintendent, Springfield Hospital, Springfield, Mass. On the other hand, Dr. Nathaniel W. Faxon, director, Massachusetts General Hospital, approved the plan and believes that the money involved will be well spent if the objectives are achieved.

Clara Quereau, secretary of the committee on accrediting of the league, explained that such a program will stimulate schools to raise their standards and will attract desirable students. Mrs. Delight S. Jones, assistant superintendent, Truesdale Hospital, Fall River, Mass., also spoke in behalf of the program.

Throughout the three day program, topics were spotted that won the attention of the hospital group. The part of the general hospital in providing for mental patients was one. Dr. Clifton T. Perkins, commissioner of the department of mental health, Commonwealth of Massachusetts, recommended that such institutions open facilities for mental patients on the basis that patients will go there more quickly and that such treatment will be more likely to effect cures.

Hospital care insurance and also plans for prepaid medical care came in for their share of attention. There is a social movement toward making medical care available to persons of all income and classes, according to Dr. Michael M. Davis, chairman of the Committee on Research in Medical Economics, New York. Mr. Davis suggested that hospital service plans in this country might even follow the examples of the contributory schemes in England in which subscribers commonly have direct representation on the

(*Continued on page* 118)

Michigan Plan Sets Record for First Year's Enrollment

The Michigan Society for Group Hospitalization celebrated its first anniversary on March 16 by issuing contract No. 175,000. This represents the largest first year enrollment of any voluntary nonprofit hospital service plan up to this time. During the first year, the society has paid $165,000 for 27,500 days of hospital service on behalf of its subscribers.

A combination hospital and surgical plan, which was made possible by the cooperation of the Michigan Medical Service, the voluntary nonprofit medical and surgical service plan sponsored by Michigan doctors, was offered recently to the employes of the Ford Motor Company. Under this plan, subscribers are protected not only against the costs of hospitalization but also against the costs of all surgical services while they are in the hospital.

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Children's Hospital, Denver, Colo.	St. Mary's Hospital, San Francisco, Calif.
Georgetown Univ. Hospital, Washington, D. C.	Spencer Hospital, Meadville, Pa.
Knickerbocker Hospital, New York, N. Y.	University Hospital, Chicago, Ill.

BARRELED SUNLIGHT

Michigan Hospital Trustees Hold First Conference; Financed by Kellogg Funds

A three day conference of hospital trustees, the first one of its kind in the United States so far as is known, was held at the University of Chicago, March 18, 19 and 20, under the auspices of the university and of the W. K. Kellogg Foundation of Battle Creek, Mich.

The conference was financed by the foundation and was designed entirely for trustees of the hospitals in Michigan, which are being aided by grants from the foundation. Forty-two trustees representing ten hospitals attended.

The fourfold responsibilities of hospitals were outlined to the trustees by James Alexander Hamilton, president of the American College of Hospital Administrators.

"Hospitals are operated for the benefit of the community as a whole," he stated. "The community may be divided into four groups: patients, members of the public who are not yet patients, physicians and employes. Undue emphasis upon the rights or prerogatives of any one of these groups is unfair to one or more of the other groups."

Mr. Hamilton presented organization charts to show typical methods of organization in large hospitals and in small hospitals. He pointed out that hospital activity can be divided into three zones, as follows: (1) determination of major policies; coordination of the hospital with governmental agencies, public health agencies and the medical profession, and development of public relations activities; (2) interpretation of those policies to the personnel of the hospital; selection and training of the personnel, and supervision of employes in the performance of their duties, and (3) actual operation of the hospital.

"The responsibilities in the first zone belong to the trustees, those in zone 2, to the administrator and those in zone 3, to the personnel of the hospital," Mr. Hamilton declared. "If the trustees try to carry on the activities in zone 2 or 3, they necessarily will neglect the much more important responsibilities in zone 1. When trustees try to administer a hospital, it inevitably begins to deteriorate."

"A hospital provides the best service when it provides the armamentarium for the physician to apply his knowledge and skill to the best advantage," declared Joseph G. Norby, administrator of Columbia Hospital, Milwaukee. "This requires a well-arranged and modern building; personnel sufficient in number, well trained, integrated, supervised, directed and loyal; up-to-date equipment; readily available and competent professional consultation service, especially in pathology and radiology; education for nurses, physicians and the community, and preparedness for emergencies."

Mr. Norby's formula for outstanding service in a hospital embraces people, ideals, ideas, execution and recognition of community needs.

Other speakers on the program included Dr. Malcolm T. MacEachern, Dr. Arthur C. Bachmeyer, Charles C. Wells, treasurer of Evanston Hospital, Evanston, Ill., C. Rufus Rorem, Guy Clark, Ada Belle McCleery, Dr. Robin C. Buerki and Graham L. Davis.

New Book by Chaplain

The Rev. Russell L. Dicks, chaplain of Presbyterian Hospital, Chicago, has recently written a book entitled "Yourself and Health," published by Harper and Brothers. Mr. Dicks is the author of two books for clergymen and one for laymen on visiting the sick.

Small Hospitals to Get Attention at Tri-State Assembly in Chicago

Special attention is to be focused on the problems of small hospitals at the eleventh annual Tri-State Hospital Assembly to be held at Hotel Stevens, Chicago, on May 1, 2 and 3 with the participation of hospital associations of Michigan, Indiana, Illinois and Wisconsin. In addition to the four associations, there will be 22 different groups participating.

New groups entering the assembly this year are bibliotherapists and laundry managers. In addition, it is expected that public relations directors will form an organization at the time of the assembly.

Among the speakers on the general assembly program devoted to small hospitals on the first day of the convention will be Kate J. Hard, superintendent, Saginaw General Hospital, Saginaw, Mich.; Mary E. Skeoch, superintendent, St. Luke's Hospital, Marquette, Mich.; Leon A. Bondi, superintendent, Galesburg Cottage Hospital, Galesburg, Ill.; Sister M. Hilda, record librarian, St. Joseph's Hospital, Joliet, Ill.; Hannah Rosser, superintendent, Vermillion County Hospital, Clinton, Ind.; Dr. E. B. Jewell, radiologist and pathologist, Cass County Hospital, Logansport, Ind., and Graham L. Davis, hospital consultant, W. K. Kellogg Foundation, Battle Creek, Mich.

The theme of the general assembly on Thursday will be "Effective Methods for Conservation of Funds Through Departmental Economies and Control of Waste." On Friday the theme will be "Recent Advances in Various Services Rendered the Patient."

Coming Meetings

April 2-4—Ohio Hospital Association, Columbus.
April 4-6—Carolinas-Virginias Hospital Conference, Winston-Salem, N. C.
April 8—Tennessee Hospital Association, Chattanooga.
April 8-11—Association of Western Hospitals, Hotel Biltmore, Los Angeles.
April 8-11—Western Conference Catholic Hospital Association, Hotel Biltmore, Los Angeles.
April 11-12—Mid-West Hospital Association, Kansas City, Mo.
April 17—Alabama Hospital Association, Birmingham.
April 22-24—Iowa Hospital Association.
April 25-26—Kentucky Hospital Association, Brown Hotel, Louisville.
May—South Dakota Hospital Association, Sioux Falls, S. D.
May 1-3—Tri-State Hospital Assembly, Hotel Stevens, Chicago.
May 8-10—Hospital Association of Pennsylvania, William Penn Hotel, Pittsburgh.
May 12-18—American Nurses' Association, National League of Nursing Education and National Organization for Public Health Nursing, Philadelphia.
May 16-17—Kansas State Hospital Association, Hotel Allis, Wichita.
May 18—Washington State Hospital Association, Spokane, Wash.
May 22-24—Hospital Association of the State of New York, Buffalo.
May 23-25—Minnesota Hospital Association, Minneapolis.
June 6—New Brunswick Hospital Association, St. Stephen, N. B.
June 6-8—New Jersey Hospital Association, Atlantic City.
June 17-21—Catholic Hospital Association, Municipal Auditorium, St. Louis.
July 28-Aug. 10—Southern Institute for Hospital Administrators, Duke University, Durham, N. C.
Aug. 11-13—National Hospital Association, Houston, Tex.
Aug. 11-24—Western Institute for Hospital Administrators, Stanford University, Stanford University, Calif.
Sept. 1-15—American Hospital Association Institute for Hospital Administrators, University of Chicago.
Sept. 1-15—New England Institute for Hospital Administrators, Harvard Medical School, Cambridge, Mass.
Sept. 2-7—American Congress of Physical Therapy, Hotel Statler, Cleveland.
Sept. 14-15—American Protestant Hospital Association, Boston.
Sept. 15-16—American College of Hospital Administrators, Hotel Statler, Boston.
Sept. 16-20—American Hospital Association, Hotel Statler, Boston.
Oct. 8-11—American Public Health Association, Book-Cadillac Hotel, Detroit.
Oct. 20-24—American Dietetic Association, Hotel Pennsylvania, New York.
Nov. 13—Colorado Hospital Association, Denver.
Dec. 5—Utah State Hospital Association, Salt Lake City.
Feb. 26—Texas Catholic Hospital Conference, Galveston, Tex.
Feb. 27-Mar. 1—Texas Hospital Association, Galveston, Tex.

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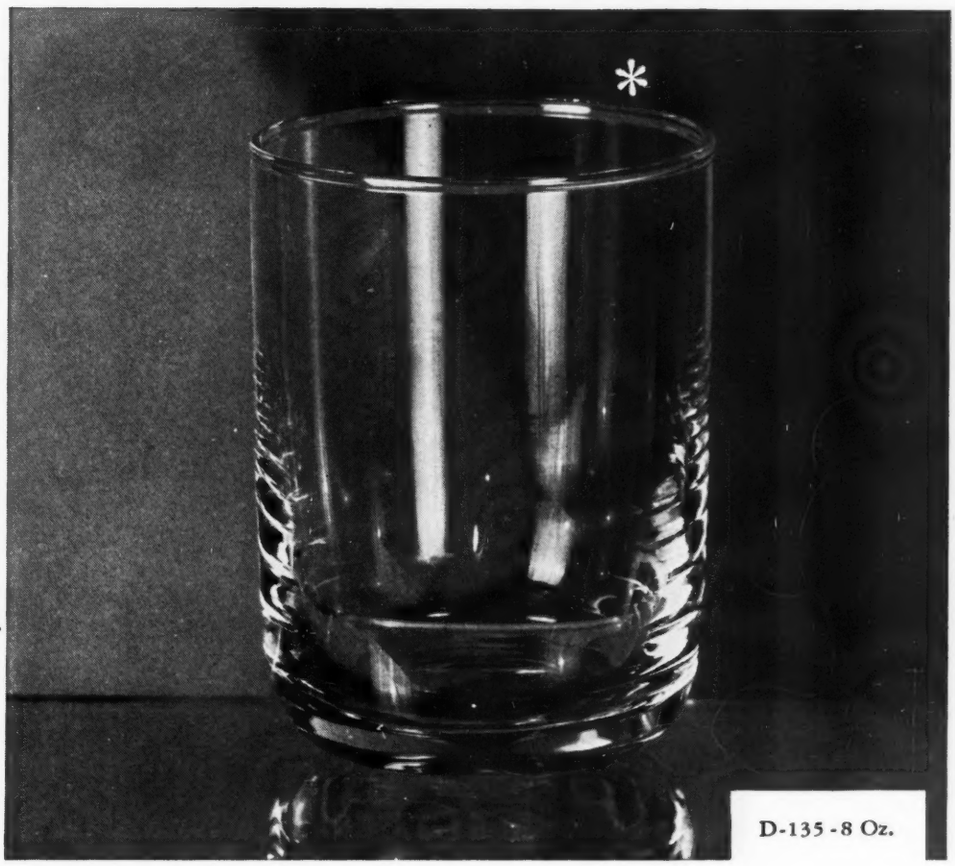

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"Spirit of the Hospital" to Be Theme of Western Hospitals Convention

The principal topic of discussion of the first general assembly of the Association of Western Hospitals meeting in Los Angeles, April 8 to 11, will be "Safety Mindedness in the Hospital." The subject will be covered from the engineering, legal, insurance and administrative standpoints.

"The Spirit of Hospital Service," will be the theme of the Tuesday morning session, with the Rev. Paul R. Zwilling, president of the American Protestant Hospital Association as the principal speaker. Sister John of the Cross, hospital consultant, Mount St. Vincent, Seattle, Wash., will lead the discussion. On Tuesday afternoon, Dr. Fred G. Carter, president of the American Hospital Association, will speak on "Institutional Policies."

James A. Hamilton, president, American College of Hospital Administrators, will address the general assembly on Wednesday morning on the subject of "Building Esprit de Corps." Ralf Couch, general superintendent, University of Oregon Hospitals and Clinics, Portland, will discuss Mr. Hamilton's paper. "Building Good Will," the subject to be covered by Dr. Benjamin W. Black, Alameda County Hospitals, Oakland, Calif., at the Wednesday afternoon meeting will deal with developing cooperative programs of public education.

Thursday morning's assembly will be devoted to the general subject of "Looking Into the Future." The speakers will be: Raymond D. Brisbane, junior past president of the Association of California Hospitals, discussing "The Hospital Plant"; C. Rufus Rorem speaking on "Hospital Service Associations," and Howard Burrell, attorney for the Association of California Hospitals, who will talk on "Legislation."

The western conference of the Catholic Hospital Association will meet on Sunday and Monday mornings, preceding the Western Hospital meeting.

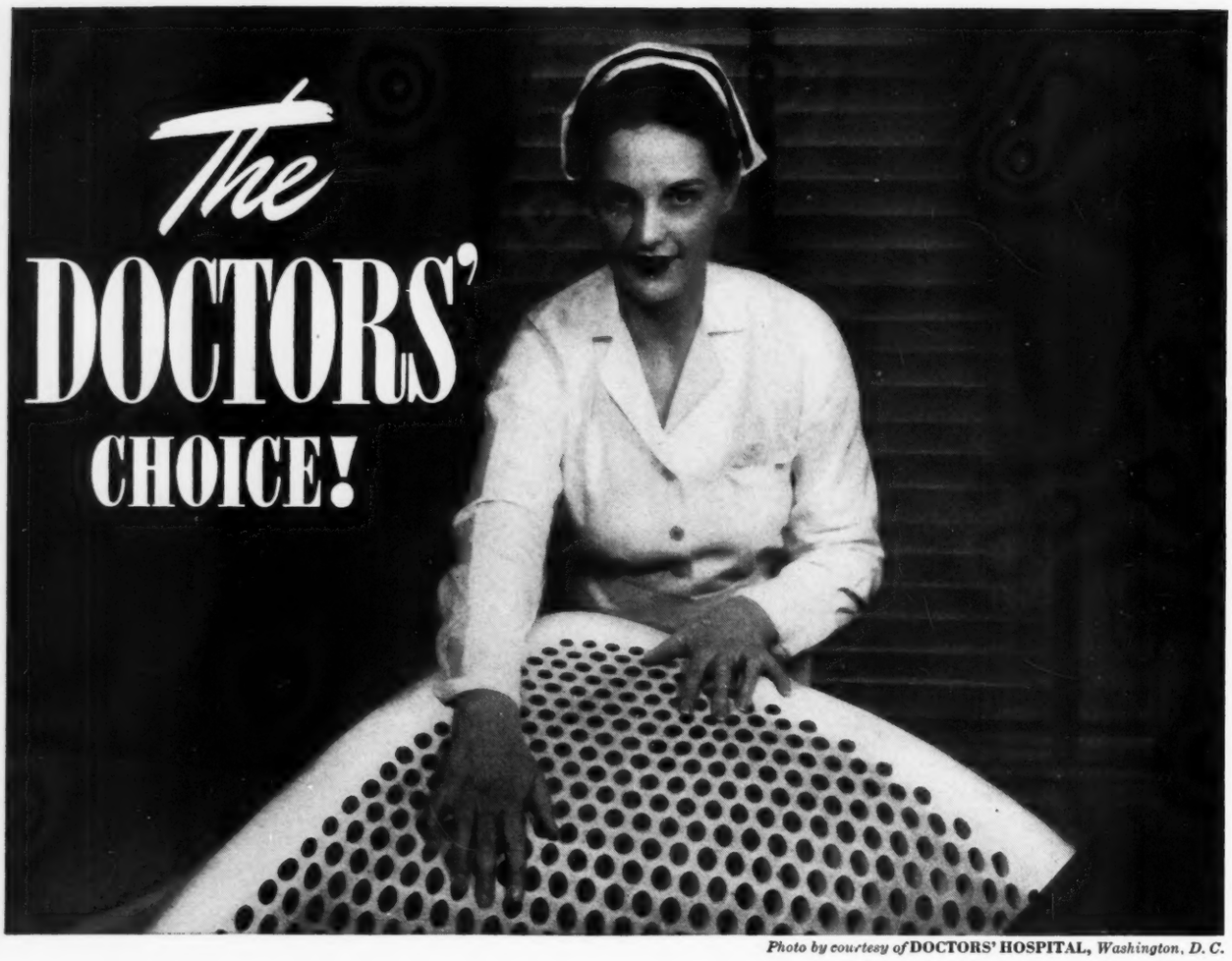
Compulsory Health Insurance Bill Introduced in New York

A bill to provide compulsory health insurance for wage earners with incomes of $1500 per year or less has been introduced into the New York State legislature by Assemblymen Robtert F. Wagner Jr. and Joseph A. Boccia, and Senator Daniel Gurman. The bill was drafted by Prof. Herman A. Gray of New York University for the American Association for Social Security.

According to Abraham Epstein, executive secretary of the association, the bill provides for hospital care, medical service and all necessary appliances and medicines. In addition to the medical benefits, disability cash allowances of from $6 to $16 per week are proposed. Funds to cover the insurance would be contributed by employers, employes and the state.

Beekman Street Hospital Seeks Funds

In urging support for the drive of Beekman Street Hospital, New York City, to obtain $117,500 to meet its estimated deficit for 1940, Wendell L. Willkie, president of the Commonwealth and Southern Corporation, on January 25 warned against the "progressive game" of government absorption of private agencies. If the hospitals are allowed to pass into government control, he said, the idea that all social agencies, and eventually economic agencies, must come under government control will be encouraged. The appeal for funds for Beekman Street Hospital was made at the same meeting by Former Governor Alfred E. Smith.



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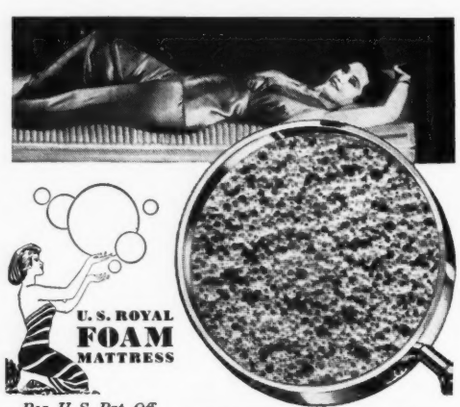

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Texas Association Has Well-Rounded Program; Jolly Given Riding Horse

Once a year the women's auxiliary in our hospital puts on a "whispering campaign" to bring home to the public the importance of the hospital in the community, declared Mrs. John G. Benson of Methodist Hospital, Indianapolis, speaking before the annual meeting of the Texas Hospital Association held in San Antonio, February 22 to 24. This has an important effect in improving the hospital's reputation, Mrs. Benson declared.

The important work of the state health department in aiding hospitals to control certain diseases was outlined by Dr. J. W. E. H. Beck of the Texas state health department. The state maintains laboratories to perform special tests for physicians and hospitals; it has venereal disease clinics to help eradicate syphilis, and it has instituted a pneumonia control program. The state also makes sulfapyradine and antipneumococcic serum available for the treatment of indigent patients with pneumonia.

"Few hospitals anywhere in the United States know the actual cost of operating the institution for a day or the cost of a school of nursing," declared William A. Dawson of the United Hospital Fund. He urged hospitals to install uniform accounting systems as has been done for 56 hospitals in New York City.

Hospital employes should be considered as a valuable asset and not discharged unless it is absolutely necessary, declared Bertha Beecher, assistant to the superintendent of Christ Hospital, Cincinnati. Miss Beecher described how they transfer employes from one department to another when they do not seem to fit in the first department. Through a well-planned and carefully executed personnel administration program, labor turnover at Christ Hospital has been drastically reduced.

The program for accreditation of nursing schools is a purely voluntary one, according to Clara Quereau, secretary of the accrediting committee of the National League of Nursing Education. She pointed out that ever since the American Hospital Association was formed as the Society of Hospital Superintendents in 1896, it had desired standards for schools of nursing. Any hospital that applies for accreditation will have its application carefully reviewed and, if in the opinion of the surveyors it is felt that the school will not be accredited, the fee will be returned and the survey postponed. "The fee of $250 being charged for inspection will not cover the expense incurred in the survey," Miss Quereau affirmed.

A five-gaited riding horse was presented to Robert Jolly by the association in appreciation of his many services to the Texas Hospital Association and to hospitals throughout the country.

New officers of the association are: Ara Davis, Scott and White Hospital, Temple, president; Harry G. Hatch, Northwest Texas Hospital, Amarillo, president-elect; Sister Evangeline, R.N., St. Joseph's Infirmary, Houston, first vice president; Eva Wallace, All Saints Hospital, Fort Worth, second vice president; C. J. Hollingsworth, West Texas Hospital, Lubbock, third vice president; Alice Taylor, R.N., Elmwood Sanatorium, Fort Worth, treasurer. J. H. Groseclose, Methodist Hospital of Dallas, is the retiring president of the association.

Four Colleges Announce Nursing Institutes to Be Held at Summer Sessions

Special nursing institutes will be offered at four colleges and universities during the spring and summer. The first one will be conducted by the department of nursing education at the College of St. Teresa, Winona, Minn., April 26 and 27. The theme will be "The Guidance Program in the School of Nursing." The charges are $2 for registration and $5 for room and meals.

Western Reserve University, Cleveland, has announced a series of courses for the graduate nurse who is interested in public health nursing, advanced clinical nursing and teaching, supervision and administration in schools of nursing. The courses will include "Public Health Nursing I"; Principles of Orthopsychiatry"; "Ward Management and Teaching," and "The Curriculum of the School of Nursing."

A symposium on clinical experience in nursing will be conducted at the Catholic University School of Nursing Education, Washington, D. C., June 26 and 27. The symposium is designed to give clinical experience in medical and surgical nursing.

Loyola University School of Medicine, Chicago, for its summer session, June 24 to August 3, has announced courses in "Methods and Materials in Health Education"; "Principles of Public Health Nursing"; "Educational Psychology"; "Physiologic Hygiene," and "Social and Public Health Aspects of Mental Hygiene."

New England Hospital Group Holds Eighteenth Convention

(*Continued from page* 108)

managing boards of the plan through representatives of their own choosing.

Describing the function of the hospital administrator, Mr. Davis stated that nowadays he must needs be more of a manager and less of a boss in the internal affairs of the institution. He must be, first, an institutional manager; second, an organizer of medical service, and, finally, a leader or an engineer of public relations. Touching on the subject of open staff policies, Mr. Davis advocated broadening the policies of hospitals whose staffs exclude certain community doctors.

Why not make the most of all the interesting historical facts that every hospital file will reveal in developing public interest in the institution? This constructive suggestion was made by Dr. E. H. Lewinski-Corwin, executive secretary, committee on public health relations, New York Academy of Medicine.

This was just one of several ideas Doctor Corwin advanced for promoting better public relations. Current material entertainingly prepared should help, but care must be taken not to overstep the bounds of propriety and good taste.

Increasing attention is being bestowed upon the hospital trustee, many of whom were discovered in the audience when Raymond P. Sloan, editor of The MODERN HOSPITAL, and trustee, Long Island College of Medicine, and Samuel Stewart, president of Central Maine General Hospital, discussed the need for greater teamwork between the hospital trustees and the administrators of each individual institution, and among trustees and administrators generally. Mr. Stewart urged that the national, state and local hospital organizations develop plans to promote the education of the trustee.

The exhibits that filled every part of the available space in the mezzanine of the Statler Hotel kept the crowd entertained when it was not attending meetings or sitting informally about the lounges outside, exchanging ideas and renewing acquaintances.

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Mid-West Hospital Group to Hear Talks on Nursing and Medical Education

The fourteenth annual meeting of the Mid-West Hospital Association, to be held in Kansas City, Mo., April 11 and 12, will open with discussions on various aspects of nursing and medical education.

At the session on Thursday morning Henrietta Froehlke, R.N., director of the University of Kansas Hospitals school of nursing, Kansas City, Kan., will present "The Accrediting Program of the National League of Nursing Education." She will be followed by Dr. Robin C. Buerki, speaking on "The Role of the Hospital in Graduate Medical Education."

At a trustees' luncheon on Thursday, Alden B. Mills, managing editor of The MODERN HOSPITAL, will talk on "Hospitals and the National Health Program."

"Maintenance Tips by an Office Building Manager" will be offered by Lewis Kitchen of Kansas City, Mo., on Thursday afternoon, after which Henry H. Caldwell of the Chicago Bar Association will speak on "Legal Problems of the Hospital Administrator."

The greater part of the Friday morning session will be devoted to a panel discussion of nonprofit service plans. The meeting will close with a talk by James A. Hamilton, president of the American College of Hospital Administrators, on the activities of the college.

American Red Cross Will Enroll Medical Technologists

At the request of the surgeon general of the Army, the American Red Cross is planning to expand its peace-time service to the military forces by enrolling various types of medical technologists who are willing to serve in the medical departments of the Army and Navy if and when their services are required, it has been announced by Norman H. Davis, chairman of the Red Cross.

Among the classes of technicians who are to be enrolled are the following: chemical laboratory technicians, dental hygienists, dental mechanics, dietitians, occupational therapy aids, pharmacists, physical therapy technicians and x-ray technicians.

The Red Cross will work through the various associations and agencies of which these technicians are members, giving them details of the plan, including requirements for enrollment.

Suggestions Distributed for National Hospital Day Programs for 1940

Because National Hospital Day falls on Sunday this year many hospitals are planning observances on Saturday or Monday. Others are planning to hold the observance on Sunday to give industrial workers an opportunity to visit their hospitals.

The National Hospital Day committee of the American Hospital Association has published a series of five pamphlets that have been widely distributed to hospitals in the United States and Canada. Leaflet No. 1 gives publicity suggestions covering proclamations, newspapers, radio, theaters, clubs, schools and churches.

Leaflet No. 2 gives suggested features for a day's program, including exhibits, and offers subjects for poster and essay contests and for cartoons and newspaper publicity. The three other leaflets contain suggestions for press releases, talks, editorials and proclamations.

A pageant of hospital history, entitled "The Flame Burns Bright," is being published by the Physicians' Record Company and is especially suited for National Hospital Day observance. It can be given by large or small hospitals.

Institute for Hospital Employes to Be Sponsored by Dallas County Council

The Dallas County Hospital Council institute for hospital employes, organized to promote better understanding of hospital problems among employes, will be held during the week of April 8 in the auditorium of the nurses' home of St. Paul's Hospital, Dallas, Tex.

Eleven papers, designed to cover as many phases of hospital activity as possible, will be presented during the institute. All the lectures will be followed by a panel discussion and round table.

Among the subjects to be discussed are the following: "Fundamentals of Hospital Administration," J. H. Groseclose, administrator, Methodist Hospital, Dallas; "Medical Staff Organization and Relationships," Dr. G. M. Hilliard, medical director, Baylor University Hospital; "Problems of the Small Hospital," T. K. Johnston, administrator, Dallas Medical and Surgical Clinic, and "Utilities, Maintenance, House Management, Laundry and Linen Service," Dr. E. M. Dunstan, administrator, Dallas City-County Hospital System.

Although the institute is primarily for the benefit of employes of Dallas County hospitals, employes of other institutions in the community are invited to attend the sessions. No registration fee is required.

Introduces Bill to Exempt Hospitals

The Association of California Hospitals has prepared and introduced into the California legislature a bill to exempt from public liability all nonprofit hospitals and other charitable, religious, scientific, literary, patriotic or educational organizations. Nonprofit hospital plans and medical plans are also exempted through the provisions of the bill. This bill, if enacted, will restore to hospitals the exemption that was recently taken from them by two decisions of the supreme court.

Pennies Pay for Baby

Sixty-five hundred pennies, weighing 45 pounds, financed the arrival in Vassar Brothers Hospital, Poughkeepsie, N. Y., of a little girl, who weighed 6 pounds 10 ounces. The child's father, Henry Weyhe, brought 130 rolls of pennies with him in a strong box when his wife was admitted to the hospital; he deposited them on the desk of the registrar in payment of the hospital bill.

Sanatorium Increases Capacity

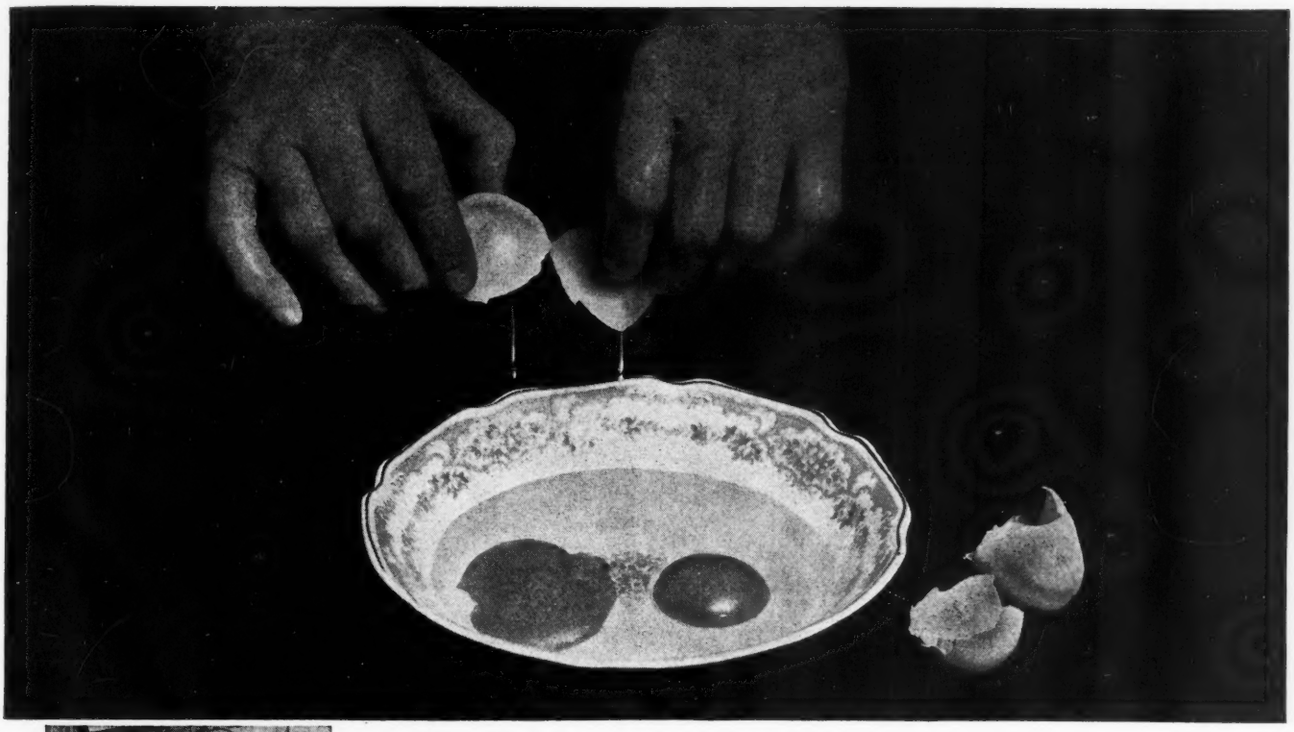
The new four story addition to St. Mary's Hospital and Sanatorium, Tucson Ariz., was dedicated on March 1. After the dedication ceremonies, the new wing was opened for inspection by the public. The structure will bring the bed capacity of the institution up to 361. Eight enclosed solariums, a sun deck and a special lounging room are the special features of the new building.

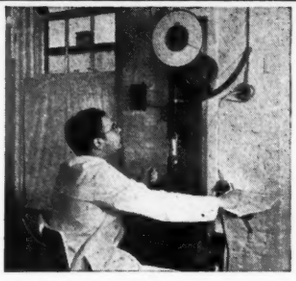
Completes Operation While Flames Rage in Hospital

Thirty-seven patients were routed from the Holden Hospital at Carbondale, Ill., when the fourth floor of the frame and brick building was practically destroyed by fire originating in the elevator shaft. Nurses, doctors and office staff worked to evacuate the patients from the upper floors and save as much equipment as possible.

While the fire was in progress, Dr. E. R. Carmen completed an emergency operation on Francis Berg, student at the Southern Illinois State Normal University, who was then transferred to St. Andrews Hospital, Murphysboro, Ill.

The damage was estimated at approximately $15,000.





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The break test tells a story too when applied to hospital apparel. To the casual observer, hospital garments may look alike, but like eggs, the break test for tensile strength proves Marvin-Neitzel clothing better. It may cost you a few cents more to buy this clothing, but that extra ruggedness, laboratory proved, saves you money on the only basis for honestly comparing costs—cost per-patient-day.

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General Hospitals Urged to Establish Pavilions for the Chronically Ill

General hospitals in Essex County, New Jersey, were urged last month to consider establishing special wards, sections or pavilions for chronic disease, in a report prepared by the department of institutions and agencies of New Jersey and submitted to the Essex County Committee for the Care of the Chronically Ill.

General hospitals were also invited to establish convalescent or nursing homes or affiliate with such institutions and to extend dispensary and special clinic service for some chronically ill patients. Clinic service, it was suggested, should include the provision of especially trained nurses to provide prescribed methods of care in the homes of chronically ill patients.

The department also suggested that present almshouses and welfare houses may be adapted to care not only for the aged but for the chronically ill who may either be indigent or have some means of support. These institutions might be enlarged or expanded to cover medical and nursing care adequate for many chronic diseases.

Broadened programs for homes for the aged to include medical care for chronics, the development of nursing homes for those able to pay and the use of visiting nurses to provide care in patients' homes in cooperation with outpatient departments were other suggestions.

Data on the number and age of chronic disease patients and the diseases from which they suffer were reported.

Commonwealth Fund Approves Site for New Illinois Hospital

The purchase of a site for a new hospital in Pittsfield, Ill., has been approved by the Commonwealth Fund, New York City. Plans for the expansion of existing hospitals at Kingsport, Tenn., and Farmville, Va., are also reported in the fund's *News-Letter*. At least 30 beds will be added to the Kingsport institution.

The Commonwealth Fund's prepayment plan has been liberalized at Kingsport to provide for family coverage; new agreements are now being prepared for distribution. Another prepayment plan has been launched by the fund-supported North Mississippi Community Hospital, Tupelo, Miss. Membership was offered to the public on July 1, 1939.

Heads Oklahoma Service Plan

Walter R. McBee, associate director of Group Hospital Service, Inc., of St. Louis, has been selected to head a similar plan that has recently been organized in Oklahoma under the sponsorship of the Oklahoma State Medical Association and the Oklahoma Hospital Association. The headquarters for the Oklahoma organization will be in Tulsa. Harley B. West, field secretary of the Group Hospital Service plan of St. Louis, will accompany Mr. McBee and will direct the new plan's activities in Oklahoma City.

Hospital Launches Drive for Funds

Beth Abraham Home for Incurables, New York City, a 300 bed chronic disease institution, has launched a drive for $150,000 to cover some of the cost of constructing and furnishing its new four story addition. One entire floor of the new wing will be devoted to active medical service. It consists of a major operating room, orthopedic treatment room, pathological laboratory, departments of physical therapy and hydrotherapy, a dental clinic, basal metabolism and cardiograph rooms, an x-ray division and physicians' consultation rooms.

A NEW *Hospital* BEAUTYREST

A SPECIAL MODEL OF THE FAMOUS BEAUTYREST MATTRESS . . . BUILT FOR HOSPITAL SERVICE

A revolutionary development in hospital mattresses. Now you can have world famous Beautyrest comfort combined with longer life and low cost.

This New Beautyrest is specially built for hospital service . . . its construction and materials are the result of extensive research. It has sufficient stamina to stand up under years of 24 hour-a-day use . . . strength to resist strains caused by posture bottom beds. In a durability test made by the United States Testing Company the New Beautyrest stood up three times as long as any of the other ten mattresses that were tested.

With the New Hospital Beautyrest you can give your patients the world's finest mattress comfort . . . comfort that they themselves would choose, as proved by the fact that over 3 million Simmons mattresses have been purchased. Independent coil action is the secret of Beautyrest's soothing support—and only Simmons has it.

This better mattress costs you no more. The longer life of the New Beautyrest makes it the most economical mattress you can use.

INDEPENDENT COIL ACTION. Each spring has an individual cloth pocket separating it from all other springs and works independently like the keys of a piano. Thus, the Beautyrest gives proper support to every part of the body even when used with posture bottom beds.

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Names in the News

Administrators

EVELYN HEATH, R.N., who has served as superintendent of Northampton Accomac Memorial Hospital at Nossawadox, Va., for the last eight years, resigned recently to accept a similar position at Columbia County Hospital, Whitesville, N. C. Miss Heath's successor is BERTIE GARDNER, R.N., who has been night superintendent of the hospital.

DR. ROBERT A. STAFF, superintendent of Smith-Esteb Memorial Hospital, Richmond, Ind., since 1936, has been appointed superintendent of the Indiana State Tuberculosis Sanatorium at Rockville. Doctor Staff succeeds DR. JEROME V. PACE, who was recently selected to serve as head of the new Southern Indiana Tuberculosis Sanatorium, now under construction at New Albany.

CHARLOTTE W. AGER, superintendent of Armstrong County Hospital, Kittanning, Pa., recently submitted her resignation to the board of trustees. She has been associated with the hospital for the last three years. FRANCES HOPKINS, assistant superintendent, will act as superintendent until a successor to Miss Ager is named.

DR. OSCAR C. HEYER of the Missouri State Sanatorium, Mount Vernon, Mo., has accepted the position of superintendent and medical director of the Kansas City Tuberculosis Sanatorium, Kansas City, Mo.

DR. CHESTER A. WATERMAN, superintendent of the Norwich State Hospital, Norwich, Conn., resigned recently. Doctor Waterman has been head of the hospital since 1934.

DR. LOUIS M. MAGEE, superintendent of the Natchez Charity Hospital, Natchez, Miss., has tendered his resignation. GOVERNOR PAUL JOHNSON has appointed DR. F. S. DIXON as Doctor Magee's successor.

DR. ROBERT CHANDLER, superintendent of the State Home for Adult Blind, Oakland, Calif., has been chosen to head the State Narcotic Hospital at Spadra, Calif., by DR. AARON J. ROSANOFF, state director of institutions. DR. THOMAS F. JOYCE, who has been managing both the Pacific Colony and the Narcotic Hospital, will hereafter direct only the Pacific Colony.

KATHREEN M. DUFFY, R.N., director of nurses at Albert Lindley Lee Memorial Hospital, Fulton, N. Y., has been named head of the hospital, succeeding HAZEL M. GOSNELL. Miss Duffy has been serving as acting superintendent since Miss Gosnell's resignation on February 1.

LORETTA E. HENGST has been named superintendent of Wayne County Memorial Hospital, Honesdale, Pa. She succeeds JENNIE HOOPER, who resigned on March 15.

OLIVER G. PRATT, superintendent of Salem Hospital, Salem, Mass., was elected president of the Massachusetts Hospital Association. Other officers chosen were: FRANCES C. LADD, superintendent, Faulkner Hospital, Jamaica Plain, vice president; DR. NORMAN C. BAKER, assistant director, Massachusetts General Hospital, Boston, secretary, and DR. WARREN F. COOK, superintendent, New England Deaconess Hospital, Boston, treasurer. FRANK E. WING, directory of Boston Dispensary, was named director for three years.

MRS. E. C. BERNHARD has been made superintendent of Jeanne's Hospital,

Fox Chase, Philadelphia. She was formerly assistant superintendent at Welfare Island City Home, New York City.

ABRAHAM ASOWSKY has been appointed assistant superintendent of the Bronx Hospital, New York City.

JOHN L. BURGAN, superintendent of Citizens General Hospital, New Kensington, Pa., resigned that position on March 1. KENNETH C. SHIRO has been named acting superintendent.

MABEL MERRICK, R.N., formerly a private duty nurse, has been chosen as the new administrator of Tuxedo Memorial Hospital, Tuxedo Park, N. Y.

Department Heads

RUTH MERCER, R.N., has been named director of nurses at the University Hospital and School of Tropical Medicine at San Juan, Puerto Rico.

HAZEL GOFF, who has been director of nurses at Grafton State Hospital, North Grafton, Mass., recently accepted a similar position at St. Luke's Hospital, Cleveland.

ANN E. PLUNKETT, R.N., for the last twelve years a public health nurse of Rensselaer County, New York, has accepted the position of superintendent of nurses at Pawling Sanitarium, Wynantskill, N. Y.

OLIVE A. ALLING, director of nursing at the Lawrence and Memorial Associated Hospitals, New London, Conn., for the last three years, has submitted her resignation to take effect on July 1.

DR. EVELYN H. CASE was recently named director of the anesthesia department at Peralta Hospital, Oakland, Calif.

ALICE M. MORSE, R.N., formerly principal of the school of nursing at Eastern Maine General Hospital, Bangor, Me., has been appointed principal of the school of nursing and director of nursing service of Children's Memorial Hospital, Chicago. MARGARET INGERSOLL, R.N., who has been acting head of the nursing school since the death of MINNIE E. HOWE, has resumed her duties as educational director.

GRACE GURNEA, R.N., took over the duties of director of nursing at Berkeley Hospital, Berkeley, Calif., on March 4.

Staff

DR. DONALD D. REALS was elected president of the staff of Faxton Hospital, Utica, N. Y., at the annual meeting. Other staff officers elected were DR. A. GRAHAM DAVIS, vice president, and DR. KEITH B. PRESTON, secretary-treasurer.

DR. FREDERIC HAGLER was named president of the staff of Wesson Memorial Hospital, Springfield, Mass., succeeding DR. SAMUEL E. FLETCHER, who refused renomination. DR. HAROLD F. BUDINGTON was elected vice president and Dr. F. P. Brown, secretary-treasurer.

DR. ROBERT T. TAPERT was honored at a dinner given for him by members of the staff of Deaconess Hospital, Detroit, when he retired as chief of staff after twenty-one years of service. A portrait of Doctor Tapert was presented to the hospital by DR. R. L. PFEIFFER, who is to succeed Doctor Tapert as chief of staff.

Deaths

MARGARET F. HILLER, superintendent of the Julia L. Butterfield Memorial Hospital, Cold Spring, N. Y., died February 16 following an abdominal operation. Miss Hiller had served as head of the hospital since its founding in 1922.

SISTER MARY GONZAGA, for twelve years head of the Mercy Hospital in Cincinnati and procurator of the Sisters of Mercy, died February 16 at the age of 64. She was superintendent of the hospital from 1912 to 1918 and again from 1921 to 1927.

TRADE NEWS

Ammonia Booster Compressor

• A booster compressor that combines both low temperature and high pressure cylinders on one frame is offered by the FRICK COMPANY, Wayne, Pa. The machine has four cylinders arranged in pairs. When built with all four cylinders in the large size, the machine is suitable for simple booster service or for use with Freon-12 in air conditioning work.

Cylinder Record Book

• The OHIO CHEMICAL AND MANUFACTURING COMPANY, Cleveland, has recently issued for the convenience of anesthetists simplified anesthesia gas cylinder record books. This organization is also offering booklets of stickers to be pasted on empty cylinders, indicating that they can be returned to the storeroom.

Low Cost Acoustical Material

• A new acoustical material, called Fibracoustic, which is described as an economical product with good noise reducing characteristics and attractive texture, has recently been marketed by JOHNS-MANVILLE, 22 East Fortieth Street, New York. The material is a wood fiber product of low density and is furnished in a variety of sizes.

Emergency Electric Light

• TRIUMPH EXPLOSIVES, INC., Elkton, Md., has recently introduced a new emergency electric light that is designed strictly for emergencies. It is claimed that no deterioration takes place before the light is required for use because the cells do not become energized until the battery is struck.

Communicating System

• An improved two way patient and nurse communicating system has recently been announced by CONNECTICUT TELEPHONE & ELECTRIC CORPORATION, Meriden, Conn. The "Connecta-call" operates in conjunction with the regular nurses' call system. A special feature is the "silent supervision" equipment by which the night duty nurse can listen in on each patient's station. The volume control can be turned up to a point at which it is possible to hear any disturbance in the room.

"Front Office" Equipment

• The W. W. WILCOX COMPANY, 564 West Randolph Street, Chicago, has issued a new catalog of hospital supplies and front office equipment. Patients' registers, information racks, operating room registers, number plates and gift plates are among the items that are described and illustrated.

Electric Typewriter

• The Burroughs front-insertion typewriter addressing machine, manufactured by the BURROUGHS ADDING MACHINE COMPANY, Detroit, is especially designed for work where a limited number of mailings to the same address does not warrant the use of address plates or stencils. Envelopes or cards are dropped in a front-feed chute instead of around the platen. The carriage, platen spacing and capital shift are electrically controlled.

Personal Notes

• John R. Hertzler has recently been named general sales manager of the YORK ICE MACHINERY CORPORATION, York, Pa.

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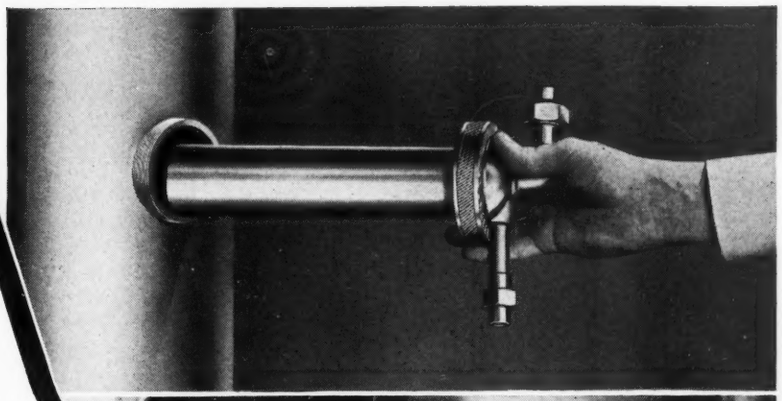

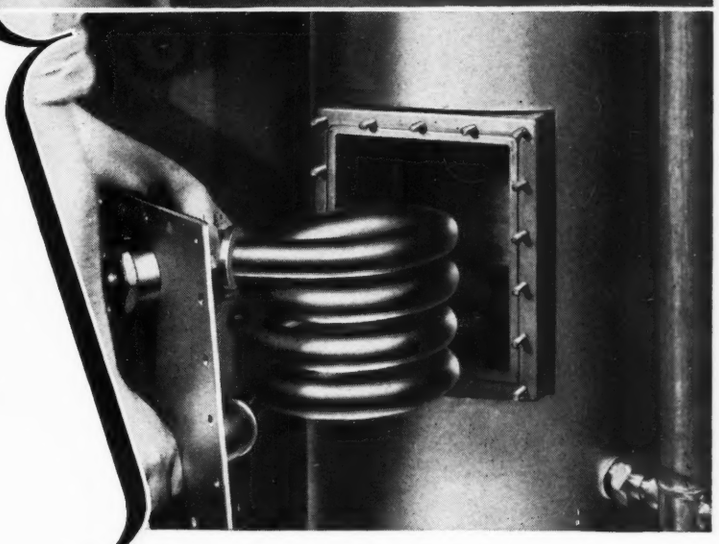

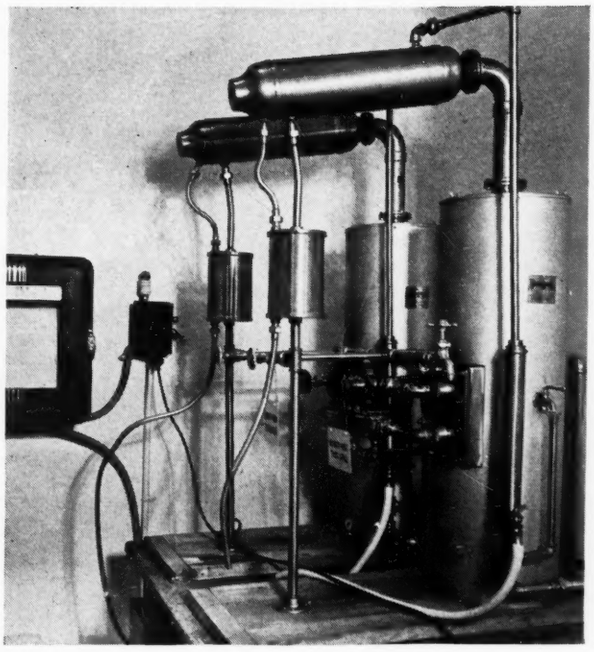

Two Modern Improvements for more efficient operation

In choosing water stills, a hospital wants two things—a pure, safe distillate and easy, economical operation. Barnstead Stills give you both. On the modern Type Q Steam-heated Stills—especially designed for hospital work—there are two new important features. The small stills—sizes 1 to 5 gallons per hour—have a new Bayonet type heater that's easily and quickly removed for cleaning. Stills from 10 gallons per hour up have a readily removable evaporator door and heating coil that greatly simplifies cleaning. With these two improvements, it's far easier to keep the still 100% efficient and your operating costs down—surer to protect your distillate from contamination.

Added to these, you get all the distinctive features that have made Barnstead Water Stills the leading choice of progressive hospitals everywhere—counter-current condensation, hot well and condenser venting, large evaporators with extra disengaging space, special Spanish Prison Type Baffles, pure tin linings, and continuous and automatic operation.

No matter what your distilled water demands are, there's a Barnstead Still that will meet them perfectly. Sizes range from ½ to 500 gallons per hour. Automatic operation by gas, steam or electricity. Stand, wall, shelf, table or concealed mountings. A complete line of storage tanks available.

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Contains complete data on all Barnstead Hospital Water Stills. Shows how they're built and how they operate. Illustrates how thousands of prominent hospitals are getting best results with Barnstead Water Stills.

BOOKS ON REVIEW • • •

PUBLIC HEALTH LAW. *By James A. Tobey, Dr. P.H., LL.D. New York: The Commonwealth Fund,* 1939. *Pp.* 414. $3.50.

The first book published in this country on the legal aspects of public health was written more than fifty years ago by two attorneys. A second, by a physician, made its appearance more than 30 years ago. The author of the present work is both a member of the bar and a physician who has long been identified with public health administration. This volume was published first in 1929; it has now been completely revised.

The book is required reading for health officials and city and town attorneys. Its well-authenticated case references and bibliography offer the reader an opportunity for further investigation of any special topic. Public health workers will find it especially helpful in interpreting the scope of legislation on this important subject.

Hospital administrators undoubtedly will profit from the chapters on the control of communicable diseases, tuberculosis and venereal diseases; the police power and the public health, and the liability of individuals and corporations in matters affecting the public health.—EMANUEL HAYT.

MEDICAL EDUCATION IN THE UNITED STATES, 1934 TO 1939. *By Herman G. Weiskotten, M.D., William D. Cutter, M.D., Hamilton H. Anderson, M.D., and Alphonse M. Schwitalla, S.J., Ph.D. Foreword by Ray Lyman Wilbur, M.D. Chicago: American Medical Association,* 1940. *Pp.* 259.

This volume contains much information relative to the development, present status and possible future of medical education in the United States and Canada. A splendid historical introduction paints the development of medical educational plans and indicates the trend of teaching methods away from the didactic toward the clinical. The organization and administration of medical schools are covered in chapter 2 and a full description of the methods of appointment, qualifications and size of faculties, as well as of leave of absence and retirement policies, are covered in chapter 3.

The remainder of the book is largely devoted to educational programs and finance and to a full description of the facilities, curriculum and methods of instruction in medical colleges.—JOSEPH C. DOANE, M.D.

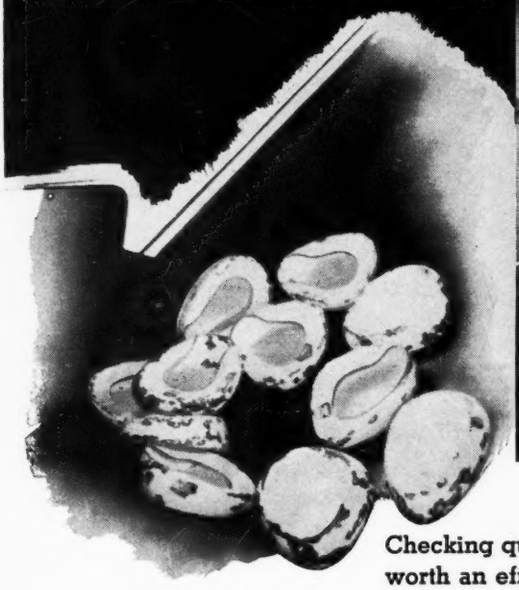
CHEF'S COOK BOOK OF PROFITABLE RECIPES. *By L. P. De Gouy. Stamford, Conn.: The Dahls,* 1939. *Pp.* 246. $3.

More than 1500 recipes are presented by a chef trained under the celebrated Escoffier. Chef De Gouy points out that the essentials of success in a good hotel or restaurant are: good food, proper service, location, intelligent merchandising, cooperation, sanitation, efficient business methods, adequate illumination, atmosphere, ventilation and sufficient working capital. Hospital dietitians who serve personnel as well as patients must also be aware of each of these points even though they may be applicable in a different way.

Each section of the book is headed by hints for the item under consideration. The recipes are not always worked out for large quantity use but from perusal one may obtain good suggestions for varying the menu. There are 380 suggestions given for salads alone.—DOROTHY DE HART.

BED PANS *were never intended for such "Service" as* THIS . . .

BUT . . . *we found out about* ENAMELWARE



Checking quality standards of merchandise is an onerous task. But truth is worth an effort. We consider it our function to investigate, to get our own facts, and to believe what we ourselves can learn rather than what we hear.

Testing enamelware is a typical and interesting example of our procedure. First, we put representative samples of bed pans from various sources in a giant Test-Tumbler — a twelve foot slowly revolving drum that carries objects high in the air, drops them, tumbles them about—a severe test, simulating years of abuse in a fraction of an hour. This was to check for strength and chipping. Then we took other pieces, burned, heated and chilled them, subjected them to acids — carried out a systematic program of destruction.

Records of the tests were kept and analyzed. Certain manufacturers' products withstood the tests better than others. These manufacturers now supply us with enamelware for hospital service . . . because we *know* we can put the Will Ross unconditional guarantee back of their merchandise.

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READER OPINION • • • •

Hospital Legislation

Sirs:

I was delighted to read your editorial on Senator Mead's bill in the March issue of The Modern Hospital. It covered the subject very well.

During the last ten years there has been a dearth of new construction and many hospitals are faced with the necessity of expanding physical facilities for which the money is not available. Many institutions do not now know where to turn for help in this important problem. If it is impossible to obtain donations for the necessary expansion of our buildings (and it seems that we have almost reached that point) the expansion will necessarily be financed to a considerable extent by funds. The opportunity of borrowing from the government upon the liberal terms contemplated by the bill mentioned will be most welcome.

Unless the hospitals do all they can to further this legislation, it will be lost in the usual "legislative jam" in the closing days of the session. If we are going to get anything as desirable as this method of borrowing funds at low cost, we will have to pay the price. That means stirring ourselves and showing that we really want such essential relief.

You know that in the absence of alert, aggressive leadership many hospitals will not take any action, so I hope you will keep the issue before them until it is settled in the right way.

Robert N. Brough,
Superintendent.

Norwalk General Hospital,
Norwalk, Conn.

The Other Side of the Case

Sirs:

A news story appeared in the February issue of The Modern Hospital under the heading, "Westinghouse Takes Out Hospitalization Policy With Equitable Life."

It is unfortunate that you should have run this story, first, because of the natural implication that it raises on coverage for as large a firm as Westinghouse by a commercial organization that is competitive with our nonprofit hospital insurance plans, and, second, because the story is contrary to the facts of the situation.

The Hospital Service Association of Pittsburgh has already enrolled the Westinghouse Air Brake, the Union Switch & Signal (a Westinghouse company), Westinghouse Bendix and the Westinghouse Electric and Manufacturing Company in Derry, Pa. We are now enrolling employes of the Westinghouse Electric and Manufacturing Company at East Pittsburgh.

Abraham Oseroff,
Secretary.

Hospital Service Association,
Pittsburgh.

Help From Advertisements

Sirs:

The advertisements in The Modern Hospital have been extremely helpful in giving us ideas for the new equipment that we are planning to purchase for the five new units in our building program. These units, incidentally, will double the present population of our institution.

Lauretta Foster,
Dietitian.

State Colony for Epileptics,
Selinsgrove, Pa.